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ABSTRACT

This study evaluated a two day institute as a means of continuing education for nurses, analyzed a method of evaluation, and examined the relationship of education and experience to subsequent learning. Background data were gathered by a structured questionnaire; unstructured interviews elicited what participants thought they had learned. Of the total sample, 91% perceived changes in their own behavior; 76% saw changes in knowledge, 62% in attitude, and 76% in practice. Over half perceived change in all three areas. The greatest change was perceived by those who were younger, married, had less education (academic and post basic nursing), less nursing experience, and were employed in the larger agencies. Little or no change was noted by those who had more education and experience and were employed with smaller agencies. Learning correlated slightly with age, basic academic education, post basic nursing education, nursing experience, and size of employing agency. It was concluded that the institute was effective for the three kinds of learning provided that the credibility of respondents was acceptable. The evaluation method (with the above proviso) was adequate for indicating change, but not for showing relationships to certain socioeconomic data. (author/ly)

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AN INSTITUTE AS AN EDUCATIONAL EXPERIENCE IN THE CONTINUING EDUCATION OF A SELECTED POPULATION OF NURSES

Jean K. Buckland

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AN INSTITUTE AS AN EDUCATIONAL EXPERIENCE IN THE CONTINUING EDUCATION OF A SELECTED POPULATION OF NURSES

by

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B.A.Sc., University of British Columbia, 1945

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
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We accept this thesis as conforming to the
required standard

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THE UNIVERSITY OF BRITISH COLUMBIA
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ABSTRACT

This study was an effort to evaluate the effectiveness of a two day institute on "Evaluation of Personnel" as an educational experience in the continuing education of nurses, to submit to critical analysis a method of evaluation, and to examine the relationship of educational and experiential backgrounds of the participants to the learning which took place subsequent to an observational analysis of the institute. An unstructured interview technique was used three months after its completion to elicit subjectively what respondents thought they had learned at the institute. The information was later arranged in a structured format for compilation, tabulation and analysis, both by punch card and computer. The socioeconomic background data was gathered through the use of a structured questionnaire at the time of the inteview. A behavioral concept of learning was used throughout.

The results revealed that 91% of the sample indicated that learning had occurred, as they perceived a change in their behavior because they had attended the institute. Further, 76% perceived a change in knowledge, 62% in attitude, and 76% in practice, while over half perceived a change in all three areas. The greatest change was perceived by those who were younger, married, had less education (academic and post basic nursing), less experience in nursing, and

who were employed in the larger agencies. The perception of little or no change was indicated by those with more education (academic and post basic nursing), more experience in nursing, and who were employed in the smaller agencies.

The comparisons of change to background factors revealed that, although none of the comparisons were consistently significant, there was a positive relationship of learning with age, basic academic education, post basic nursing education, years of nursing experience, and size of employing agency. Marital status, husband's occupation, parental status, income, social participation, years of head nurse experience, size and type of nursing unit and size of staff showed some interesting comparisons by observation, but the sample proved too small for accurate inferences to be drawn.

The conclusions of the study were that the institute was effective as an educational experience for continuing education in the three aspects of behavioral learning examined, provided the credibility of the respondents was acceptable. The instrument used was adequate for the purpose of indicating change of behavior with the above proviso, but not adequate for revealing whether change was relevant to certain socioeconomic data. No claim can therefore be made concerning the relationship between this data and learning in a situation such as this institute.

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CHAPTER I

THE PROBLEM, THE RELEVANT RESEARCH, THE STUDY

Social and Occupational Change

As the social institutions of our society have become increasingly bureaucratic, the need for personnel with administrative skills in the management of people and production has increased. The production explosion of the Second World War demonstrated the results of inadequate and inexperienced managerial personnel.[1] It also demonstrated the effects of training these people how to supervise and teach their subordinates. Training usually resulted in increased production and decreased turnover of personnel in both industry and business.

Nursing, like many professions, has undergone major changes in the past twenty-five years. Some of these changes have had internal causes, but many have been influenced by technical changes in the medical and paramedical fields. Although constant changes may make an occupation more interesting, they may also constitute a threat to those with feelings of inadequacy in a shifting situation. Many problems and general unrest among nursing personnel have been created, causing decreased quality of nursing service, high turnover of staff, and increased cost in staff replacement.

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[1] References will be collected at the end of each chapter.

Lack of Leadership

The graduate nurse has been educated to give direct patient care rather than to assume administrative duties and to direct the work of others, such as are inherent in the leadership role.[2] Many nurses have found themselves in leadership and supervisory positions with the resulting conflicts between what they learned to do and what they were actually doing in the everyday work situation.[3] Approximately 23% of nurses in Canadian general hospitals were in positions of assistant head nurse or higher in 1967.[4] The number of people required for administrative functions has always exceeded the number available with the necessary leadership and supervisory preparation.[5]

Various nursing studies have concluded that twenty-five to thirty-three percent of nursing positions need as one requirement a baccalaureate or higher degree.[6] Countdown 1968 stated that of 120,000 registered nurses in Canada in 1967, 5% had a baccalaureate degree in nursing, 0.4% had a higher degree, 9% had some credits toward a baccalaureate degree, and 8% had a university diploma or certificate in nursing.[7]

In 1966, one study reported that, of one hundred head nurses, four had a degree, twelve had a one year university diploma course in nursing, eleven had a hospital clinical course, and four had completed a correspondence course in nursing unit administration.[8] (Appendix A).

In 1967, Mussallem stated that there was "a colossal waste of nursing skills," which she attributed to poor supervision and high staff turnover.[9] Lack of preparation caused supervisory personnel uneasiness and feelings of inadequacy, which often undermined the security and confidence of their subordinates. Lack of preparation also made their administrative functioning inadequate in many cases. One Canadian study on staff turnover indicated that work load was the largest single significant factor involved.[10]

The cost of replacing those who leave their positions involves money, effort, and time for the employing agency and for the employees who remain. One American study estimated the personnel processing cost of replacing one general staff nurse in a general hospital to be five hundred dollars.[11] Since there was an estimated 61% turnover rate for general staff nurses in Canada in 1967, the implications of the American study are obvious.[12] Turnover rates were 16% for head nurses, 16% for supervisors and 17% for hospital nursing directors in 1966.[13] The highest turnover of all nursing positions was greatest in hospitals of over 300 beds.[14]

The Canadian Nurses Association outlined the factors involved in job satisfaction which, it believed, would influence the high rate of turnover of all nurses.[15] These factors included orientation procedures, administrative policies, personnel policies, inservice education, staff organization, supervision and evaluation, the opportunity for advancement, participation in professional organizations, and further education. A consideration of the quality of these factors might actually decrease the turnover rate.

Continuing Education for Nurses

Both the Canadian and American Nursing Associations have reported that nurses are asking for continuing education programs to add to their basic knowledge and to meet their developing needs.[16,17] Many of these needs have arisen through changing technical knowledge, but many have arisen through the promotion of the nurse into supervisory positions for which she was not fully prepared. Employing agencies have been interested in updating their staff members because improved knowledge has usually improved the quality of patient care. Most hospitals have provided inservice education programs for various levels of workers to keep them up to date with changing practices. Also, staff members have usually been encouraged to attend whatever educational courses are available.

A large number of short term training courses, institutes, and workshops have been conducted for nurses during the past ten years in both Canada and the United States. No matter how good the basic preparation of the nurse may have been, such courses were considered necessary for her to keep up with current knowledge.

Many short courses have been given in administrative and leadership subjects to enable those without sufficient preparation for their positions to function more adequately. The courses were considered stopgaps which would continue only until enough properly prepared people became available. Baccalaureate programs are increasing across Canada, and several universities now offer Masters' programs. As graduates from these programs become more numerous, the need for short courses in administration and leadership may be expected to decrease except as refresher courses.

In the United States, over 10,000 nurses, or roughly 15% of those eligible, attended 300 courses in management training between 1960 and 1963.[18] A nursing unit administration correspondence course has been completed by over 1,500 Canadian head nurses and supervisors since its inception in 1960.[19] A summary and evaluation of this course is given in Appendix A. Recently the number of applicants has exceeded the enrollment capacity of the course. Hereinafter this course is referred to as the N.U.A. course.

Evaluation of Continuing Education

Many nursing and educational groups across the country have instigated programs of management training for key personnel in nursing.[20,21] This has been done in an effort to increase the utilization of available staff through their improved effectiveness as a result of attending such programs. From a practical standpoint, the results have been disappointing to researchers as improved performance has not always occurred subsequently.[22] Nursing leaders have felt that lip service rather than changed performance has resulted.[23] Behavioral researchers, however, regard any change following a program as progress.[24]

Cheek and Gruenfeld write, "While management development programs apparently fail in their manifest functions, they serve a number of equally important latent functions."[25] One of these latent functions was the changed view of themselves and their jobs which participants often had. With this changed view, the participant was likely to function differently on her return to her job, with results which were likely to be beneficial to both herself and her employing agency. A speaker at a conference on the professional nurse traineeship program stated, "There is no known method of statistically measuring the quality contributed by an educated spirit as well as an educated mind. Nor is it easy to assay the illimitable influence of leadership."[26]

Studies germaine to the evaluation of continuing educational experiences for nurses were reviewed, and are summarised below.

The Utah Study. In 1960, a regional continuing education project was started at the University of Utah College of Nursing to improve the skills of nurses in administrative, supervisory and teaching positions.[27] Six short conferences were held over a two year period with thirty of the original thirty-four participants completing the series. The program "was designed to make changes in the direction of greater understanding and more democratic attitudes on the part of participants." Evaluation of the program had as its objective determination of the extent to which learning and/or attitude change took place following the educational experiences.

The evaluation instruments used were: a) a special trait check list, b) the Helen B. Lenehan Inventory of Nursing Routines, c) a Superordinate Interview Scale, d) a WICHE Supervisor Rating Scale, and e) a Subordinate Rating Scale. The first two scales were discarded because they were judged as not sensitive enough. The last three scales covered, to different degrees, but generally, the areas of efficiency, competence, initiative, stress, and interpersonal relationships. Superordinate and/or subordinate ratings were obtained on all participants and on 23 control subjects by the same person both before and after the series of conferences, approximately two years apart. Of the conference participants, 30% were evaluated by the superordinates and subordinates as needing little or no training, and the other 70% were evaluated as needing training to some extent in all areas. The control group did not attend any of the conferences.

The conclusions of the study were that the conference participants improved while the control non-participants did not. The results were strongly suggestive that the conferences were responsible for the improvements. Of the instruments used, two were judged not sensitive enough, one was questioned as being somewhat unreliable, and no specific comments were made concerning the others.

The WICHE Study. Under the aegis of the Western Interstate Commission on Higher Education, eight university schools of nursing in twelve western states carried out seven leadership training programs.[28] Each trainee attended six one week conferences over a two year period. The major objective was to aid the participants in becoming more effective leaders, on the assumption that effective nurse leaders create a climate in which high quality nursing care can be provided by their staffs. Using new approaches to learning, it was hoped that greater group awareness and acceptance of the need for change would develop. The aims of a concurrent research project were to develop instruments for evaluating selected attitudinal and behavioral changes, to test the reliability of the instruments developed, and to determine the degree of change resulting from participation in the continuing education program.

An experimental group of 410 nurse leader participants and a control group of 450 nurse leader non-participants were compared on several research devices and instruments both before and after the two year program. Overt behavior was measured with a situational exercise by three people, and by rating scales for on-the-job leadership and interpersonal skill by one supervisor and three subordinates. Both groups of subjects also completed: a) the Nahm Nurse Opinion Inventory, b) the Todd Personnel Relations Test Part I and Part II. As well as the above, the experimental group, half way through the program, was given a) the Biographical Inventory, b) the Registered Nurse's Self Description Scale, and c) the Registered Nurse's Satisfactory Achievement Scale.

The research results indicated a change in the desired direction of expressed attitudes and beliefs regarding leadership and interpersonal relationships. However, changes in behavior to correspond with the attitudinal changes were not clearly demonstrated.

The authors agreed that the participants had identified with more democratic and understanding attitudes, but that the pressures of the day-to-day work situation were against change. As the seminars or conferences were only interruptions in the usual pattern of work, it was difficult to break through the barriers of apathy to obtain personal involvement and commitment. The roles and relationships in nursing have been very ambiguous, and become further complicated by the individual nurse's perception of her responsibility for nursing care. They concluded, however, that any movement in a positive direction was progress. The report stated that the instruments developed were inadequate.

The Texas Study. In 1958 an acute shortage of nurses in the State of Texas precipitated a two year survey of nursing needs and resources.[29] A proposal for improving conditions through "strengthening the skills of those who are now responsible for directing the nursing care of patients" resulted.[30] A Management Skills Training Workshop for 'nurse managers' was set up, and in 1960 three five day workshops followed by a three day workshop were instigated over a seventeen month period for each nurse participating. During the four years of the project, 1,700 nurses, or 28% of those eligible, took part.[31]

The assumptions underlying the program were that training based on changing attitudes would lead to changes of behavior, as changing attitudes and values are part of occupational socialization. Occupational socialization was defined as "a process by which individuals selectively acquire the skill, knowledge, attitudes, values, and motives current in the groups of which they are, or will become, members."[32] The report explained that those changing their occupational role, from bedside nursing to the supervision of others doing the bedside nursing, needed to change their value systems to those of the work group which they had joined. The research project method was to gather information regarding short and long term effects of the program on the participants and on their employing agencies.

During the training program, six multi-item instruments were used at various stages. Two were devised specifically for measuring information in this study, and four were modified from attitude scales developed for other studies. The first information test was constructed by the project members but discarded later, as seven of the original fifteen items were judged not discriminatory enough. The second information test was developed from an analysis of training publications and consisted of 26 items, of which 17 were found to be sufficiently discriminatory. The four attitude scales were a) the democracy scale, b) the functional orientation scale, and c) the consideration and initiating structure scales. The instruments were considered relatively reliable as the coefficients reported were comparable to those reported for similar short tests.

The study revealed a change in knowledge for all participants,[33] and a change of attitude toward more democratic and functional orientations for most participants. These attitudes tended to persist and in the predicted direction.[34]

Performance evaluation, or a change in practice, was determined through three different types of special sub-studies. These were, essentially, a) a Proficiency Rating System used in the Veterans

Administration hospitals (80 participants), b) the Nurse Management-performance Instrument used in 8 hospitals (41 participants), and c) an interview and questionaire used in six hospitals (11 participants). For the last performance evaluation sub-study, control "cases" were matched with the experimental "cases." These "cases" each included the participant, one supervisor and two subordinates.

The number of persons given above were those followed throughout the study. Because of technical difficulties, the original interviewees were reduced to these numbers and the samples were not considered as random selections of conference participants.

The attainment of attitude change occurred in the first performance evaluation sub-study but there was little evidence of performance change. The second sub-study reported performance improvement at the lowest level of conventional confidence. This group showed significant but low correlations between changed attitudes and changed performance. The third sub-study did not prove that improvement occurred, but did reveal that the social structures of the work group can impede or permit changes and that there was little evidence that experimental "cases" would change their performance more than the control "cases." The results tended to both support and negate the expected performance change.

The report then stated that evaluation of change and actual change could be contradictory. In support of this the authors examined self reports of performance change and reports of changes in the employing agencies of the participants. Self reports of performance change varied from none to many, with areas of change different from those anticipated. Performance improvement was evidently not general, but in specific areas which had been given low priorities on the original assessment. Agency changes were reported by over half the directors employing participants as either new practices being instituted or existing practices being improved. In one way or another, a change in performance occurred for most participants, although the authors stated that those who were pleased with the conferences may have had inflated ideas of the amount of change which actually occurred.[35,36]

In the conclusions of the study the authors discussed the controversies which exist over which criteria may be accepted as indicative of success, and over the level of attainment of these criteria before the outcome is judged as successful.[37] From a social research[38] viewpoint, the program was successful, determined from both attendance of initial participants, and their degree of satisfaction with the program. The latter varied depending upon the education and experience of the participants. The final statement of the study is

> This report has shown clearly that it is difficult to demonstrate that a management-training program has achieved its objectives, that the trail of cause and effect is hard to follow, that criteria are hard to select and measure, and that judgment is an essential part of the process.[39]

Relevance of the Present Study

The previous studies were concerned with courses or conferences while the present study is concerned with an institute.

An institute, in continuing education terminology on this continent, is a one to three day program of lectures or presentations, alternated with group discussions.[40] In the inexact terminology of continuing education, the institute can also be described as a study-conference, refresher-conference, or short school. The participants usually have a common occupational or professional background and gather to add new information to their basic knowledge of a particular aspect of their field. Institutes are described as most advantageous for the acquisition of knowledge rather than for practicing or applying it.[41,42,43,44]

Those attending the institutes under study held assistant head nurse positions or higher in their employing agencies.[45] Geitgey described a head nurse as the immediate supervisor of an individual ward or clinical area.[46] Her supervisory and educational efforts are directed to the greater efficiency and better performance of her staff members for the improvement of the nursing care of the patients in her area.

The supervision and evaluation of personnel was the subject of the institutes. This aspect of administration has often been a source of anxiety, conflict, and confusion to many in supervisory positions, but especially to those without preparation because they have not understood the rationale and implications of the processes involved.[47,48,49]

This study was an approach to the evaluation of an institute as an educational experience in the continuing education of a sample of the participants. The reader will observe that none of the studies reviewed were concerned with an educational experience as intensive as this two day institute.

Purpose and Scope of the Study

The purposes of the present study were: 1) to evaluate an institute as an effective tool in continuing education for nurses, and 2) to subject a method of evaluation to critical analysis. Evaluation of the institute was attempted through 1) a subjective evaluation by the selected sample of their perception of change in their own behavior following participation in the institute; 2) an analysis of perceived change in knowledge, attitude, practice, or a combination of these, and 3) an examination of whether differences in perceived changes were related to differences in educational and experiential background (general and professional).

Provision for increasing knowledge and for modifying attitudes can be included in a well designed two day institute. Information about improving practice can be provided, but provisions for application cannot. The institute under study was therefore subjected to an observational analysis in terms of knowledge, attitude, and relevance to practice. Summary mention of the governing factors in this analysis is given in Chapter III. As the analysis is based on the behavioral concept of learning, a review of the literature on learning and the factors influencing it can be found in Appendix E. As the motivation for continued learning, and employment itself, may be conditioned by socioeconomic factors such as the need to earn money, a secondary exploration of the correlation between expressed opinions and selected socioeconomic aspects of the participants was undertaken.

The study was exploratory in that the methodology and results might contribute to further studies in evaluation from which conceivably appropriate instruments and techniques for objective measurement may be developed in the future.

The sample used for the study was randomly selected from a population consisting of those registered nurses attending the institute who lived within a certain geographic area. Each nurse was interviewed individually by the author, usually at the nurse's place of work. The interviews were held over a six week period starting approximately three months after completion of the institutes.

The interview used in this study consisted of a) formal questions concerned with socioeconomic and demographic data about the individual, and b) a discussion to elicit those changes of behavior perceived by the person as occurring because she had attended one of the institutes.

Limitations of the Study

This study was concerned only with the interviewee's perception of any change in her behavior because she attended the institute. As with any subjective study, this one was limited by the subjective attributes of the interviewees regarding their perception of their own behavior, and the impressions of the interviewer regarding these statements. Changes may or may not have occurred, although the interviewee may have felt that she should show a positive appreciation of the institute as she had been chosen in the interview sample. Interviewer-interviewee interaction could also have affected the outcome of the study, particularly when the recording and measurement of changed behavior was dependent upon unstructured interviews.

There was no way of predetermining the composition of the population or of pretesting the individual's unique procedures of evaluating staff performance before the institute. In any event, no standard measures of staff performance evaluation techniques have yet been established.[50,51,52,53]

Apart from practical difficulties, there is a theoretical basis for the avoidance of pretests or baseline tests in studies of subjective evaluations as distinct from objective measurement of newly acquired knowledge. When the respondents are aware of what is expected, the halo effect is more in evidence than would otherwise be the case.[54]

The sample could have been affected positively or negatively by those respondents who were just completing the N.U.A. course (Appendix A). This was not known before the interviews. The population from which the sample was selected, although geographically limited, proved to be characteristic of the population and the profession in major socioeconomic factors.

The sample, including the socioeconomic and demographic information gathered during the interviews, is the subject of the next chapter.

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38. In this paper, "social research" was used in the same context as in the Texas study, i.e., as "behavioral research."

39. McLemore, *op*. *cit*., p. 151.

40. Adult Education Association of the U.S.A. *Conducting Workshops and Institutes*. Chicago. 1956. p. 3.

41. Dalhousie University School of Nursing. *Institute on Staff Education.* Halifax. 1964.

42. Bergevin, P. *et al*. *Adult Education Procedures*. Greenwich, Conn. Seabury. 1963. p. 223.

43. Morgan, B. *et al*. *Methods in Adult Education*. Danville, Ill. Interstate. 1963. p. 57.

44. Munger, P.F. *et al*. Guidance Institutes and the Persistence of Attitudes. *Personnel Guidance Journal*. 1963. 41:415-419.

45. Although those who attended the institutes were both general and psychiatric nurses, only those participants who were registered nurses in the Province of British Columbia were considered in the population of this study.

46. Geitgey, D.A. *A Handbook for Head Nurses*. Philadelphia. Davis. 1961. p. 3.

47. Barabas, M.H. *Contemporary Head Nursing*. New York. MacMillan. 1962. p. 32.

48. Barrett, J. *Ward Management and Teaching*. New York. Appleton, Century, Crofts. 1949. p. 47.

49. Gorham, W.A. Methods of Measuring Staff Nursing Performance. *Nursing Research*. 1963. 12(1):4-11.

50. Tate, B.L. Evaluation of Clinical Performance of the Staff Nurse. *Nursing Research*. 1962. 11:7-9.

51. Tate, B.L. *A Method for Rating the Proficiency of the Hospital Staff Nurse*. New York. National League of Nursing. 1964.

52. Tate, B.L. *Test of a Nursing Performance Evaluation Instrument*. New York. National League of Nursing. 1964.

53. Gorham, *op. cit.*

54. McLemore, *op. cit.*, p. 123.

CHAPTER II

A DESCRIPTION OF THE SAMPLE

The Population and the Sample

A two day institute on "The Evaluation of Personnel" was held twice in Vancouver, B. C., in March 1968. It was conducted by Miss K. Ruane of Winnipeg, under the sponsorship of the Registered Nurses Association of British Columbia, and the Department of Continuing Medical Education, University of British Columbia.

There were 242 registered nurses participating in these institutes, all of whom were employed as assistant head nurses or higher. The population for the study consisted of those living within a one-hundred mile driving radius of Vancouver, B.C., and was chosen for easy accessibility for interviews. The resulting number of registered nurses was 189.

From this population of 189, a 35% sample was chosen from random number tables,[1] using alphabetically listed names of participants.[2] This sample list included a 25% study sample and a 10% alternate list. As the interviews were held during the summer months when vacations occur, it was anticipated that some of the sample might be unavailable. The final sample included only two from the alternate list to replace two who had left British Columbia since the institute.

Background data were gathered in order that differences among those comprising the study sample might be identified. A structured interview schedule was designed to seek the following facts: marital status, including the husband's occupation [3] and parental status of those married; age; income; social participation rating;[4] basic academic education; non-nursing education; location of school of nursing associated with basic nursing education; year of graduation; type of hospital associated with school of nursing; amount and type of post basic nursing education; years of nursing experience; years of head nurse experience; size of employing agency; type of nursing unit; size of nursing unit; size of staff; and perception of the institute.[5]

The resulting interview schedule is in Appendix B. From the answers to this schedule obtained during the pilot study (discussed in Chapter III), it was decided that the questions were suitable for use as an instrument without change.

Characteristics of the Sample

The data in this section were derived from the interview schedule, recorded on punch cards and tabulated. This was later verified by univariate tabulations on a computer. The answers to each question regarding background characteristics were combined in various ways to simplify presentation of the data. Either the median scale value or the combination which gave the most significant statistical differences in later comparisons was used. The data is presented in percentages for clarity. Unless otherwise specifically stated, percentages are of the total sample throughout the study.

Marital status. The sample was almost equally divided between those who were married (49%) and those who were single (42%) or widowed (9%). Of those who were married, 59% had one or more children. (Figure 1)

Of the Canadian head nurses working in hospitals in 1967, 55% were married, 41% were single, and 4% reported another marital status.[6] Of the 653 registered nurses in British Columbia employed as head nurses or assistants in 1967, 54% were married, 32% were single, and 14% reported another status.[7] Figure 3 shows the marital status of these three groups. As there is no statistically significant difference, this comparison can be interpreted to mean that the sample is relatively representative of head nurses in Canada and in British Columbia in marital status.

Occupation of husbands. Blishen designed an occupational scale for workers based on socioeconomic and demographic data acquired from census information.[8] This scale ranks occupations from Class 1 for the professional group, to Class 7 for the unskilled laborer. The greater the skill required by an occupation, the higher its prestige, and the higher the social position of those in this occupation. According to this scale, almost a third of Canada's working population is in Class 5, which includes many skilled and semi-skilled trades. Graduate nurses are in Class 2. The occupations of husbands of the married respondents ranged from Class 2 to Class 7, with a median category of Class 4. (Figure 2) This category is below that of nurses but above that of the general Canadian population. Twenty-seven percent

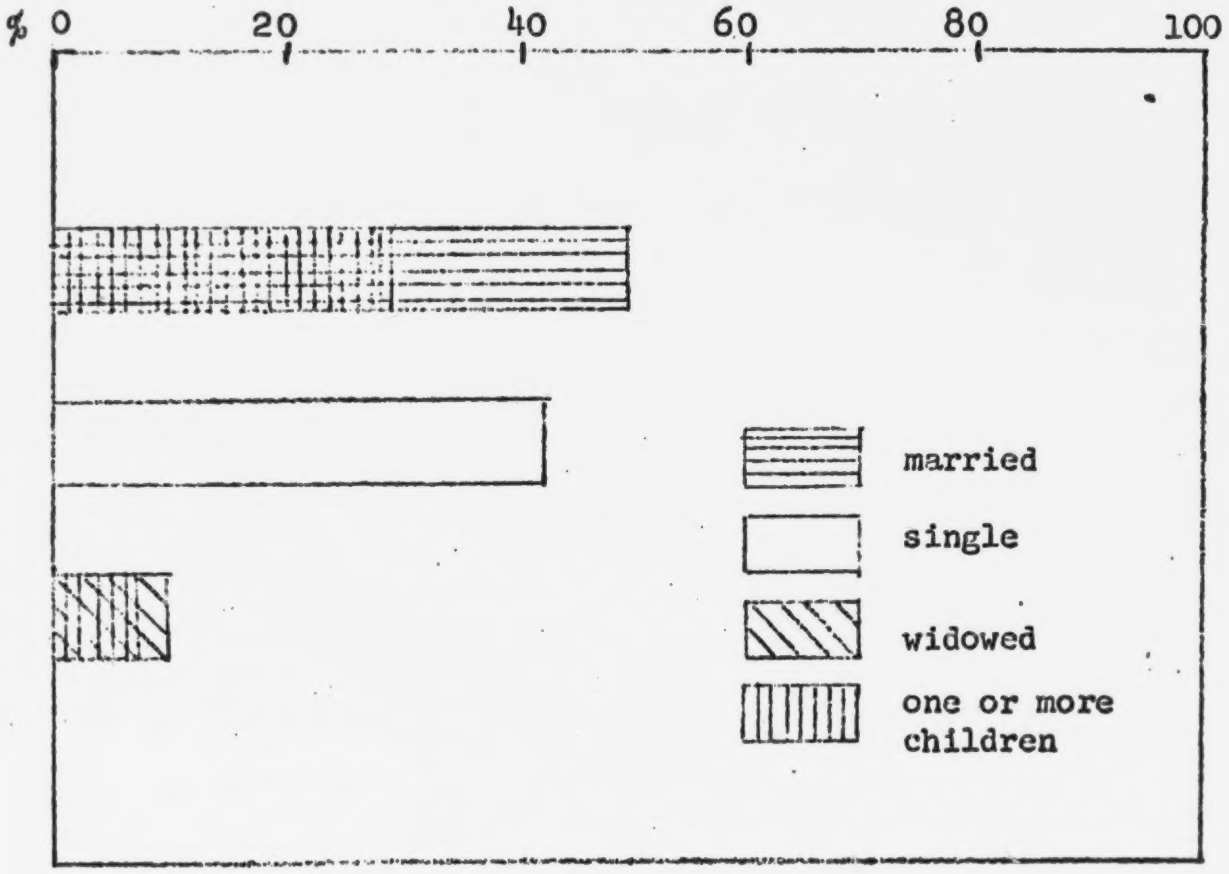

Fig. 1. Distribution of the sample by marital and parental status.

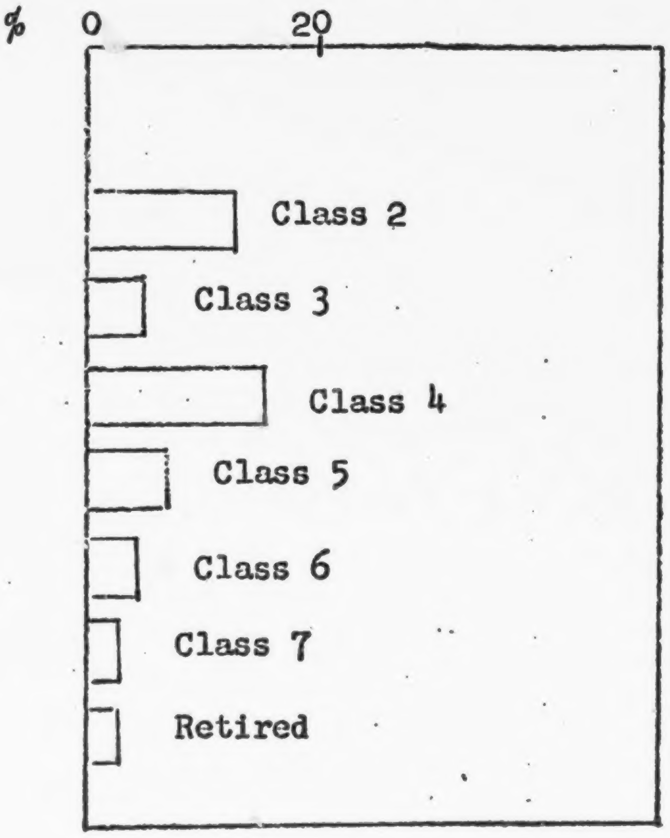

Fig. 2. Occupation of husbands on the Blishen Occupational Scale.

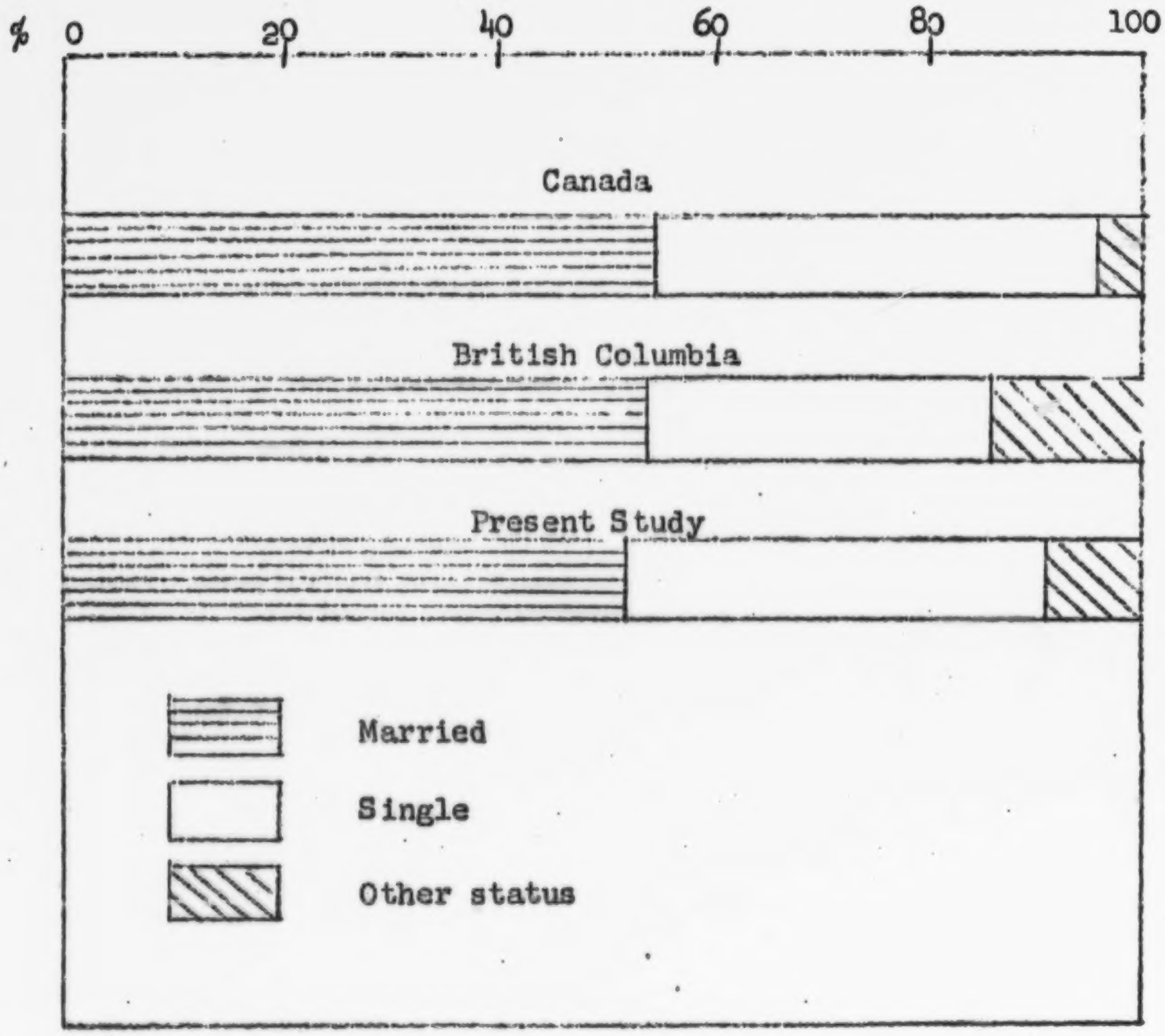

Fig. 3. Distribution of marital status of head nurses in Canada, British Columbia and the present study.

of the husbands were in the same occupational class as their wives.

Age. The age distribution of the sample ranged from one respondent under 25 years to three over 60 years, with the median category being 45 to 49 years. Of the sample, 51% were 45 years of age or over.

The age distribution of head nurses in British Columbia in 1967 ranged from less than 1% under 25 years to 7% over 65 years of age, with the median category being between 45 and 49 years.[9] Figure 4 depicts the age distribution of the provincial head nurses with those in the present study. As there is no statistically significant difference between the two groups, the sample is relatively representative of British Columbia head nurses with regard to age distribution.

Income. The gross annual income ranged from $5,000 to $8,999, with 80% receiving between $6,000 and $6,999 annually.

When the annual incomes of the respondents in the study are compared to the statistics for annual incomes for nurses in Canada and British Columbia, those in the study are average. As the British Columbia figures were a little higher (about $300 a year) than the Canadian figures, these nurses will now be well above the Canadian average income as contract changes in British Columbia in 1968 raised the basic annual income by almost $1,500.[10]

Social Participation. Chapin's Social Participation Scale measures the degree of a person's participation in community groups and institutions.[11] The extent of participation is measured by the number

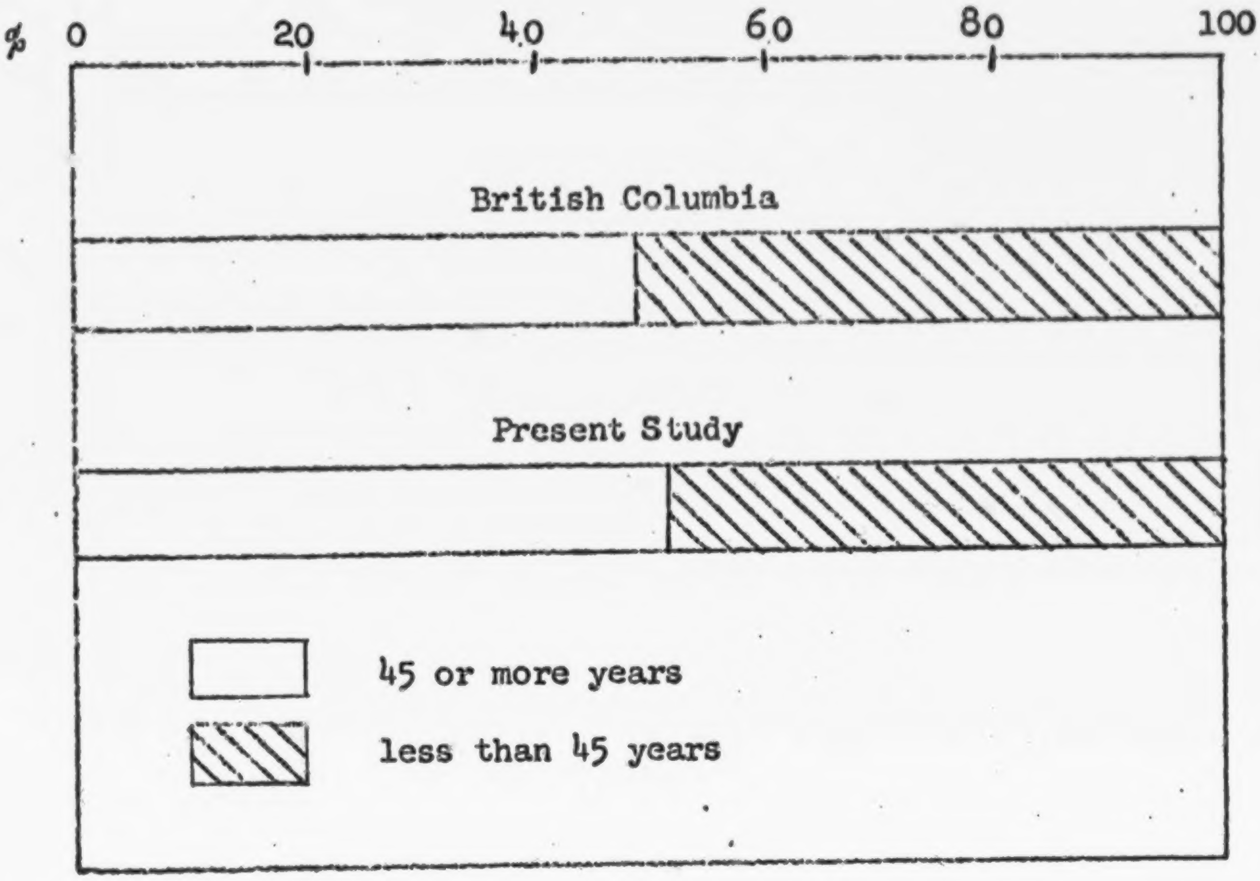

Fig. 4. Age distribution of head nurses in British Columbia and in the present study.

of memberships held during the previous year, and the intensity or degree of involvement is measured by attendance at meetings, financial contribution, committee memberships, and the holding of offices. Each of the component parts counts toward a rating on Chapin's Scale. The higher the rating, the greater the social participation of the person. The scores in the present study ranged from three to over thirty-five, with an average of sixteen. (Figure 5) Chapin states that the average score for professional and managerial occupational groups is 20, or four points above the study average.

Basic Academic Education. Seven percent of the sample completed two or more years of university education, 22% completed first year university, 64% graduated from high school and 7% did not finish high school. (Figure 6) Basic academic education for those entering a program of professional nursing education is controlled by law in all Canadian provinces, and requires a satisfactory standing in certain high school programs. Those in the sample with less than high school graduation entered schools of nursing before 1935, when amendments to required educational standards were made to the Registered Nurses Act. of British Columbia, originally passed in 1918.[12]

Non-nursing Education. Eleven percent of the respondents had taken business or secretarial training, and 16% had training in areas other than nursing following their basic academic education. Sixty-four percent had taken noncredit continuing education courses during the past five years and 87% hoped to do so in the future.

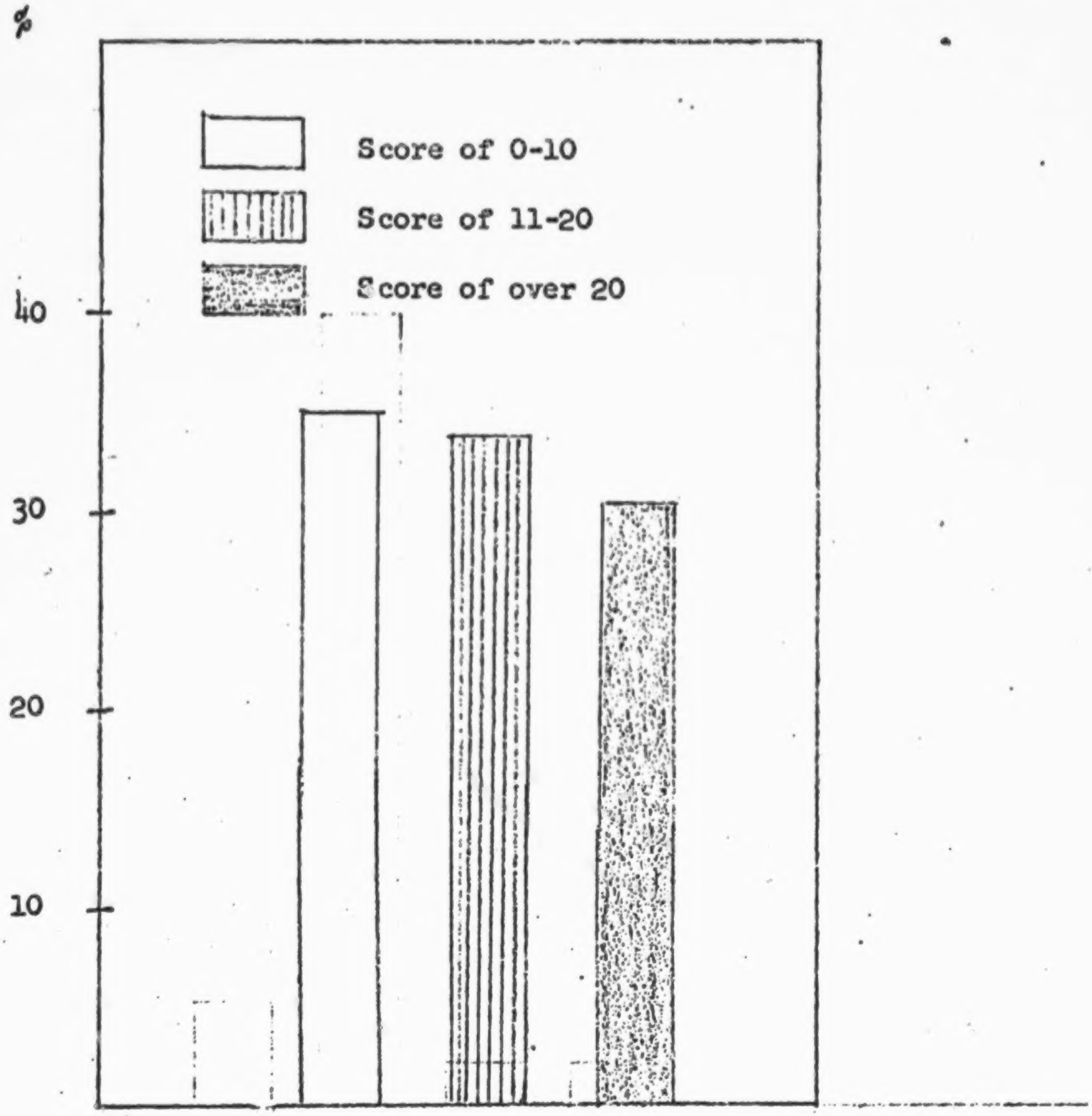

Fig. 5. Distribution of the sample on Chapin's Social Participation Scale.

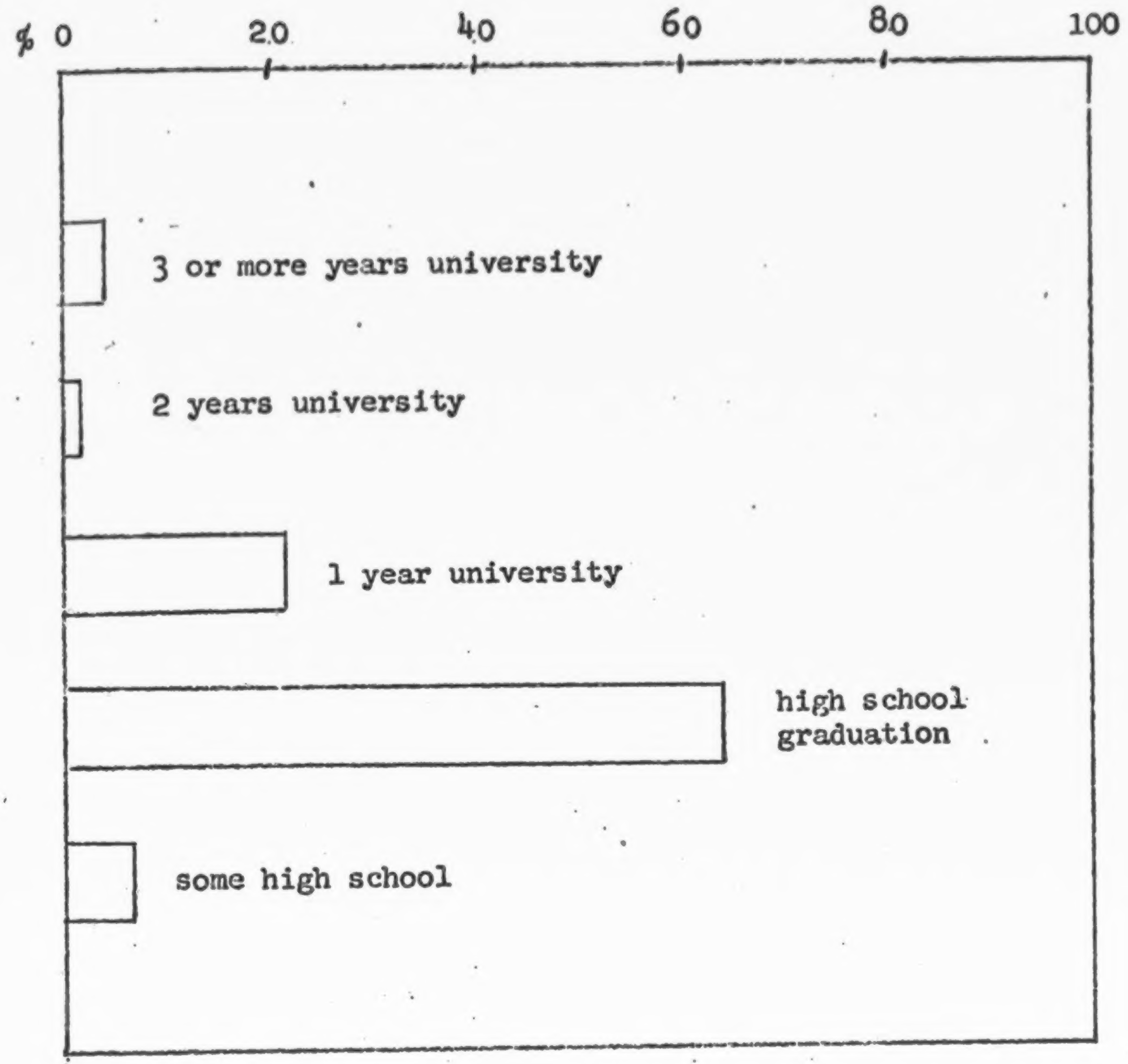

Fig. 6. Distribution of the sample by basic academic education.

Basic Nursing Education. Forty-seven percent of the respondents graduated from schools of nursing in British Columbia, 40% in other parts of Canada, and 13% in Great Britain. There were no graduates from other countries represented. The years of graduation ranged from 1930 to 1967, with 24% graduating before 1940, 33% between 1940 and 1949, 24% between 1950 and 1959, and 18% since 1960. All respondents graduated from general hospital schools of nursing.

Post Basic Nursing Education. Thirty-eight percent of the respondents had no post basic nursing education, 31% had completed the nursing unit administration course (Appendix A), 11% had completed a post graduate hospital clinical course, and 18% had at least one year of university nursing education. Only one respondent (2%) had a baccalaureate degree in nursing. (Figure 7)

A comparison of head nurses with and without at least one year of post basic university nursing education was made between Canadian statistics as listed in Countdown,[13] Campion's Study,[14] and the present study. (Figure 8) This comparison showed that 12% of Canadian head nurses, 16% of Campion's respondents and 20% of the present sample had one or more years of post basic university nursing education. As the differences were not significant, the study sample was relatively representative of Canadian head nurses, and comparable to the respondents in Campion's study regarding post basic university nursing education.

Campion's study[15] of nursing in Canada provided an interesting

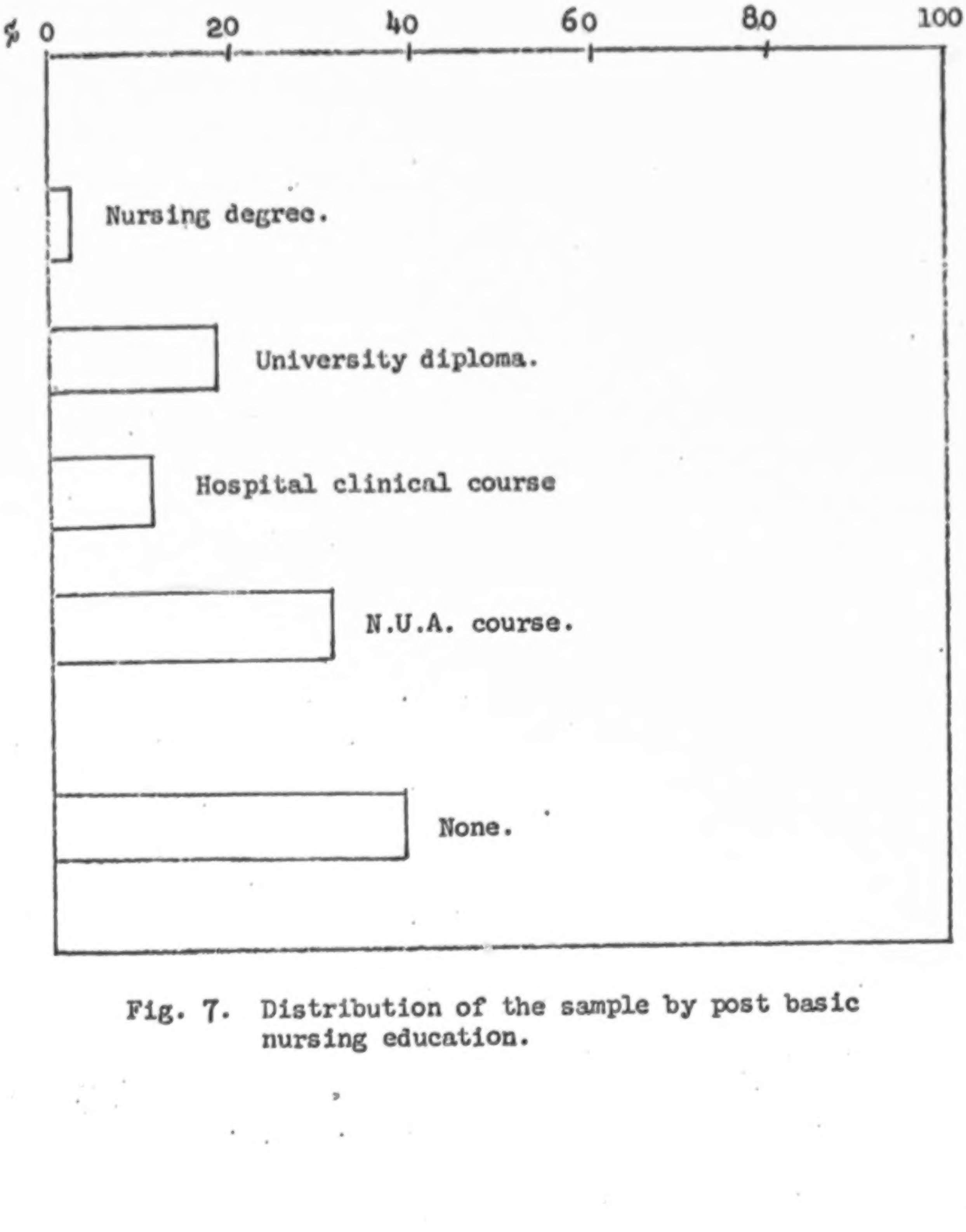

Fig. 7. Distribution of the sample by post basic nursing education.

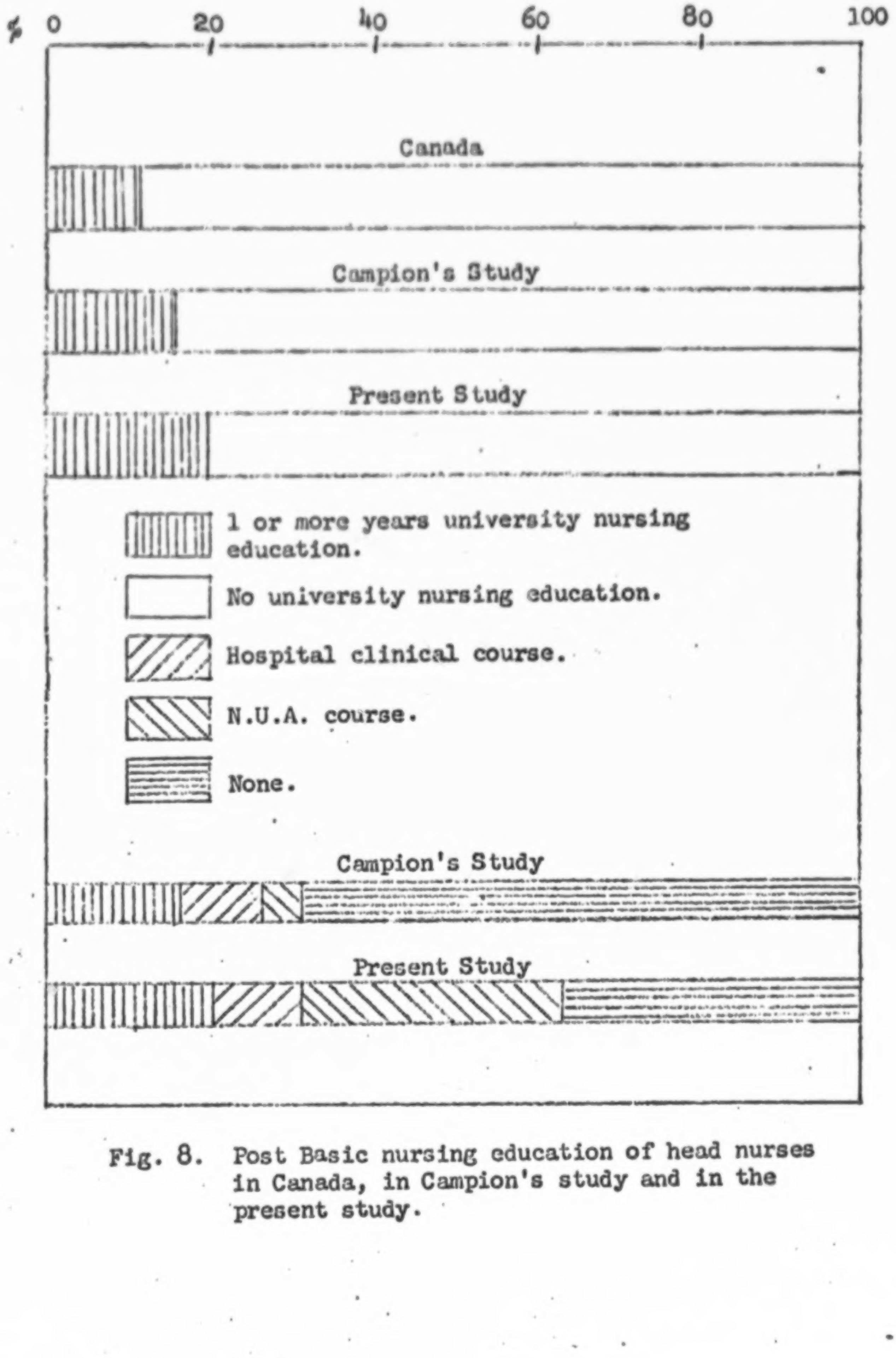

Fig. 8. Post Basic nursing education of head nurses in Canada, in Campion's study and in the present study.

set of statistics for comparison with data in the present study. Figure 8 shows that 69% and 38% of the respondents respectively had no post basic nursing education, 4% and 31% had completed the N.U.A. course (Appendix A), and 27% and 31% had completed a hospital clinical course or had at least one year of post basic university nursing education.

Why the correspondence course was so much more evident in the present study may be interpreted several ways. The differences might be due to the demand for education by nurses, the course being required for or strongly suggested by employing agencies to those unprepared for their head nurse positions, or a disproportionate number of past or current N.U.A. students being at the institutes because of their high interest. During the two years since publication of Campion's study, a larger percent of the sample had an opportunity to complete the course than in Campion's group. During 1967 and 1968, 12 of the study sample were students in the N.U.A. course. If these respondents were reallocated to the category of those with no post basic nursing education, the distribution would become 64% with no extra education, and 5% with the course, instead of 38% and 31% respectively. These new figures were not significantly different from those of Campion's study.

Other nursing courses, mostly clinical, had been taken by 18% of the sample during the previous five years.

Nursing and Head Nurse Experience. The respondents had nursing experience which ranged from less than five years (7%) to over 35 years (4%). A total of 67% of the respondents had more than 15 years of nursing experience. (Figure 9) Fifty-six percent had five or more years experience as a head nurse. Only 11% of the respondents could be considered novices with less than a year of head nurse experience. (Figure 10)

Size of Employing Agency. Three of the respondents (7%) worked in health agencies other than hospitals, 53% worked in hospitals of less than 500 beds, and 40% worked in larger hospitals. (Figure 11)

Type and Size of Nursing Units. Sixty percent of the respondents worked in medical-surgical nursing units. Nine of the respondents (20%) worked in public health agencies or transient patient areas, 33% worked in units of less than 30 beds, and 47% worked in larger units. (Figure 12)

Size of Staff. Thirty-eight percent were responsible for personnel numbering less than fifteen, and 62% were responsible for more. (Figure 13) The head nurse was responsible for the supervision and evaluation of these staff members unless her supervisor did the reports and/or the interviews. Student nurses were included in a few cases, and the head nurse assisted the instructor in doing the reports or did them herself.

Perception of the Institute. One only answer was elicited from each respondent on the Kropp Verner Attitude Scale (Appendix D)

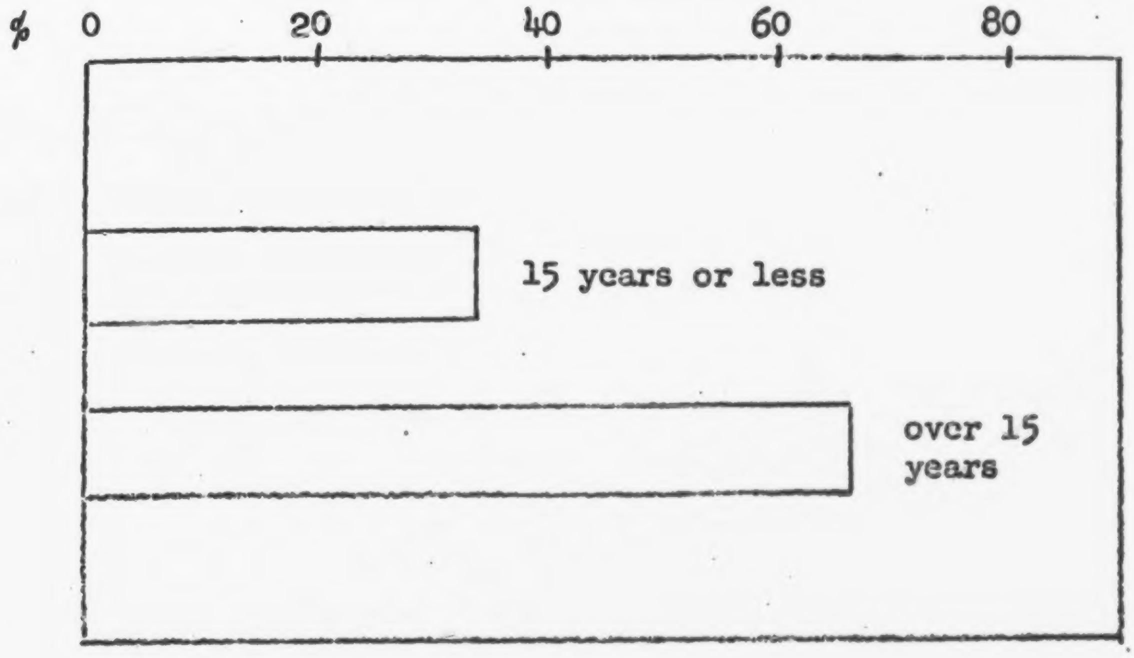

Fig. 9. Distribution of the sample by years of nursing experience.

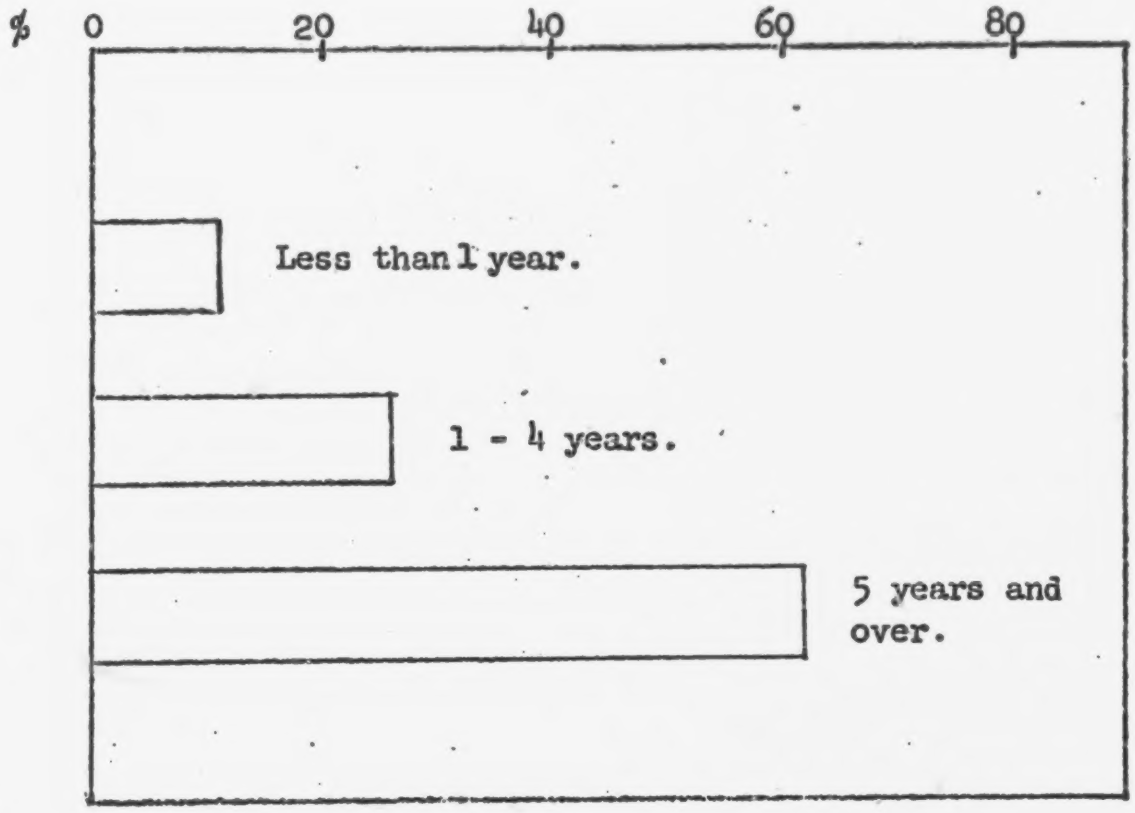

Fig. 10. Distribution of the sample by years of head nurse experience.

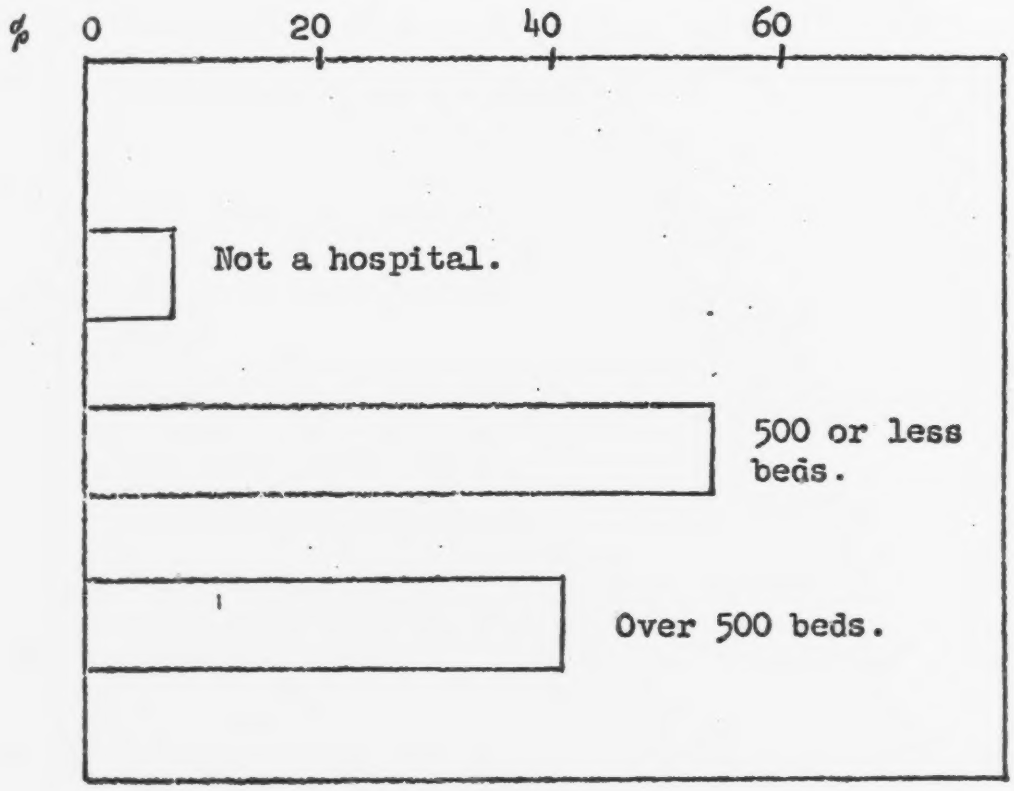

Fig. 11. Distribution of the sample by size of employing agency.

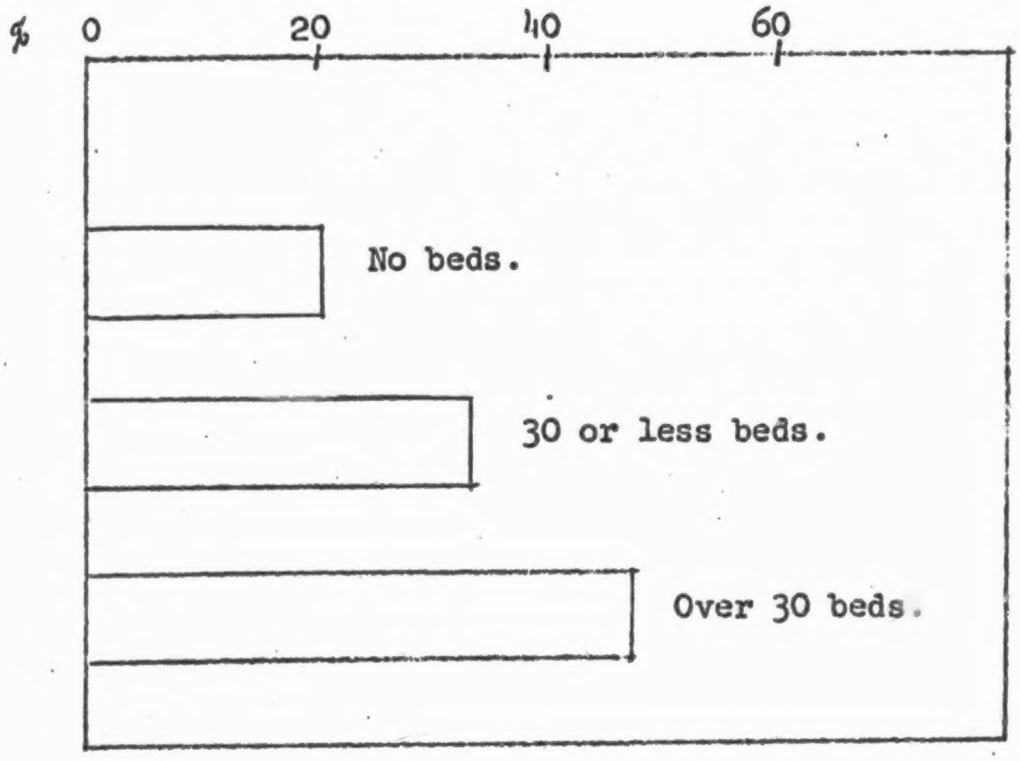

Fig. 12. Distribution of the sample by size of nursing unit.

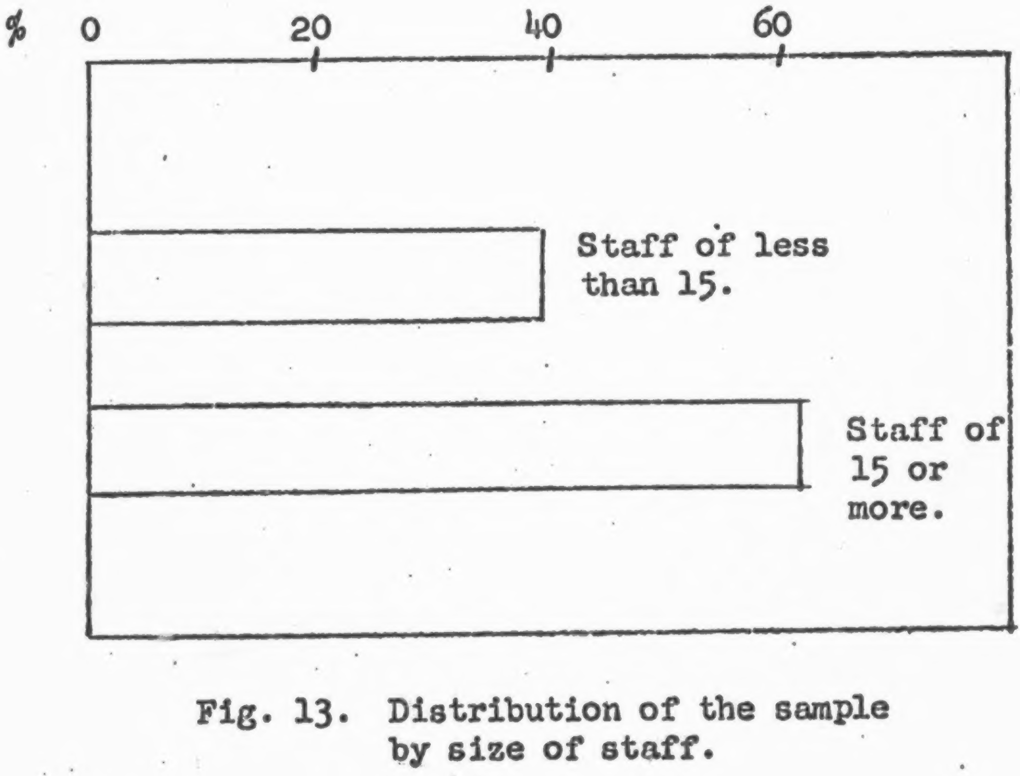

Fig. 13. Distribution of the sample by size of staff.

which measures the general attitude of the respondent toward an organized educational experience.[16] The median rating for all respondents was Item 5, "It helped me personally." The ratings are shown in Figure 14.

Comparison of Background Categories

The various combinations of each background category were compared with one another. These comparisons were originally done on punch cards and later verified on a computer. A probability of .05 was chosen as the level of significance, calculated with the chi square test when the observed frequency was over five, and with the Kolomogorov-Smirnov test when the observed frequency was smaller.[17] All figures showing comparisons in the text and in the graphs are at this level or better, unless otherwise indicated.[18] Ten percent of the sample, or 4.5 individuals, was a very small frequency for the statistical treatment of observed variations, however.[19] (see Tables I and II, p. 52 and 53)

Of the 841 tables which resulted from these comparisons 21 showed differences at or above the chosen level of significance. Some of these added nothing meaningful to the results of the study. For example, of those with over 15 years of nursing experience, 73% were over 45 years of age, and 73% had been head nurses for over five years. Of those with less than 15 years of nursing experience, 7% were over 45 years of age, and 20% had been head nurses for over five years. (Figure 15)

Of the married respondents, 86% had high school graduation or less, 41% had been head nurses for 5 or more years, and 82% were responsible for staffs of 15 or more people. Of the unmarried

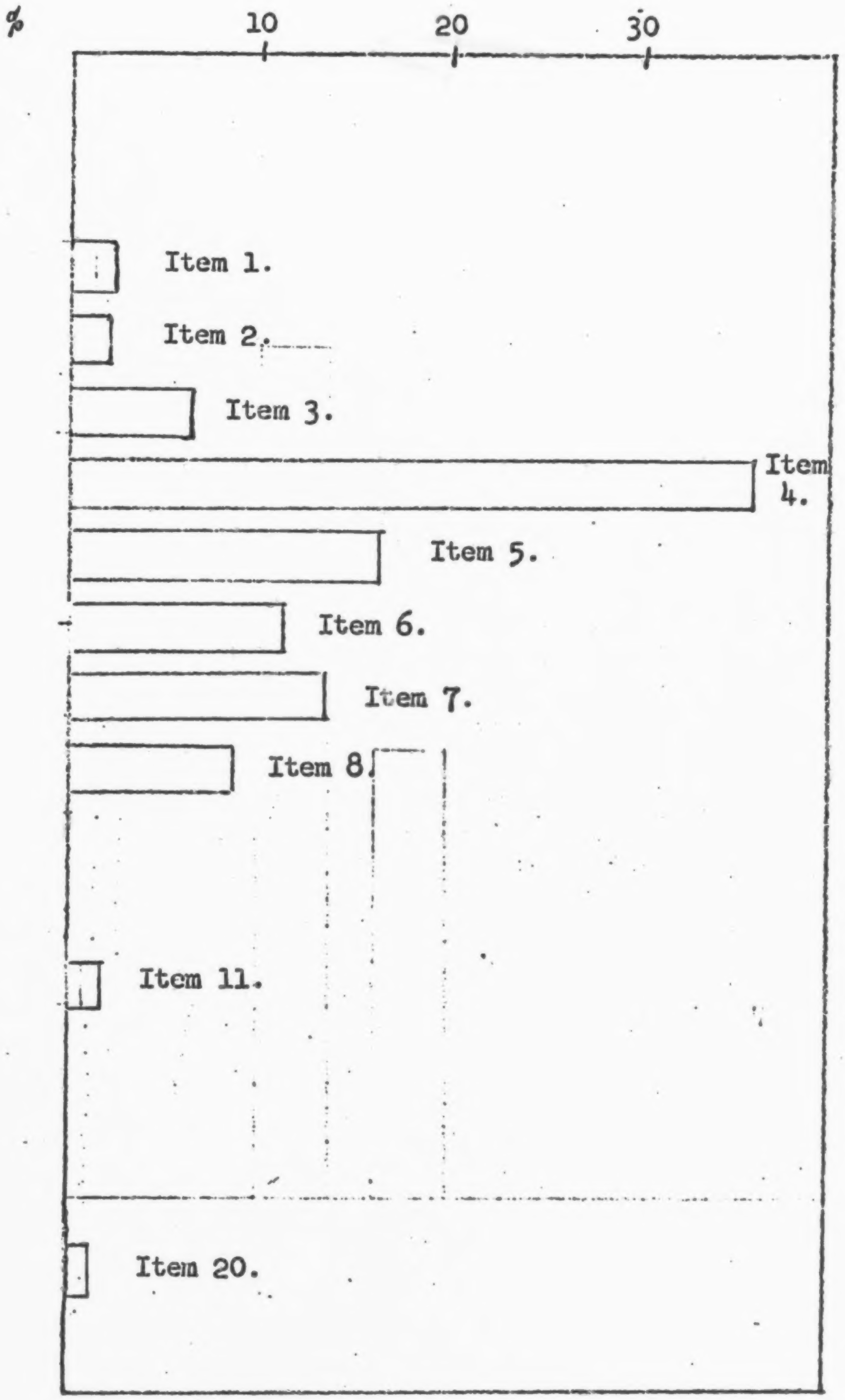

Fig. 14. Distribution of the sample by rating on the Kropp Verner Attitude Scale.

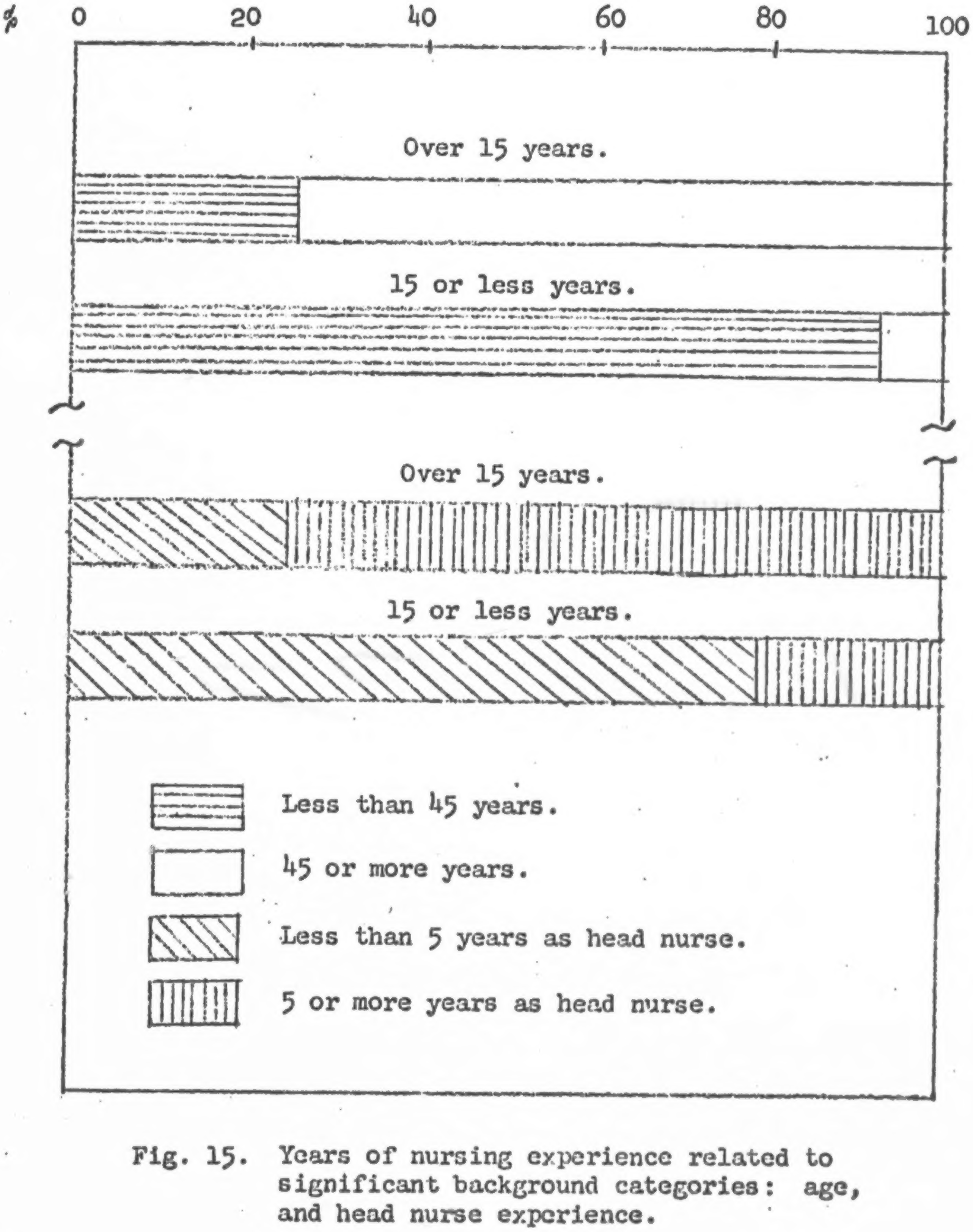

Fig. 15. Years of nursing experience related to significant background categories: age, and head nurse experience.

respondents, 57% had high school graduation or less, 70% had been head nurses for 5 or more years, and 43% were responsible for staffs of 15 or more people. (Figure 16) What these differences mean is difficult to determine. The differences in basic academic education may mean that the two groups had different career goals, or that the unmarried group achieved further education later. At the time of the interviews, the respondents were not asked for details regarding their education, other than how much they had completed. The difference could show a trend toward career orientations for those who remain in nursing. The difference in the number of each group who had been head nurses for over five years would be accounted for by fewer of the more experienced group being married. The responsibility for large staffs is an interesting difference. Whether those who remain in nursing gradually take over smaller nursing units, and therefore smaller staffs, or whether they become charge nurses in more specialized areas, again with smaller staffs, is problematical.

Of those under 45 years of age, 18% had completed the N.U.A. course, and 27% had other post basic nursing education; 77% were responsible for staffs of 15 or more. Of those over 45 years of age, 43% had completed the N.U.A. course, and 37% had other post basic nursing education; 48% were responsible for staffs of 15 or more. (Figure 17) As would be surmized, there were significant differences with the year of graduation, years of nursing experience, and years as a head nurse. Those who were older had more nursing education than the younger group, possibly because of the career and time differences. The

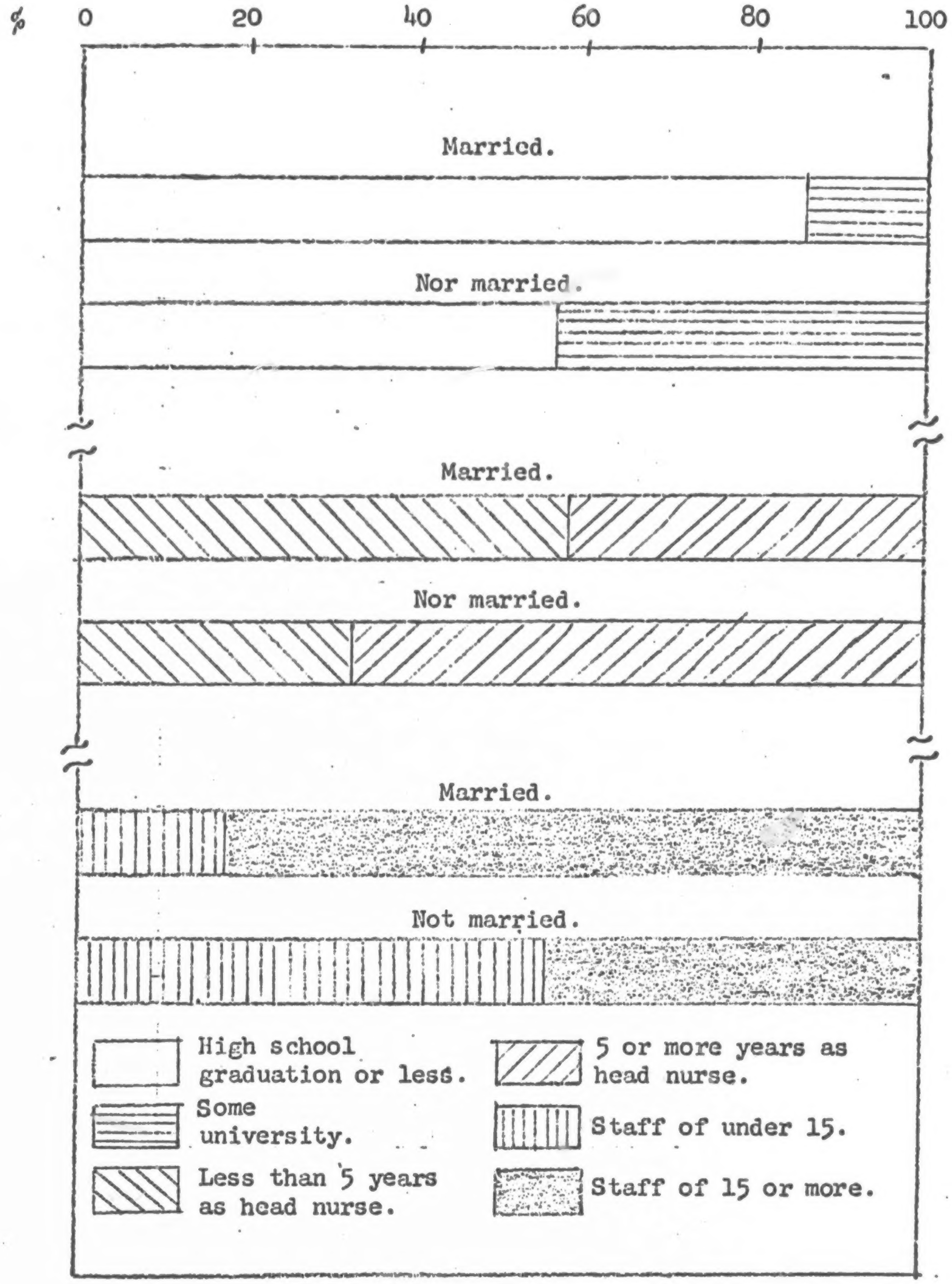

Fig. 16. Marital status related to significant background categories: post basic nursing education, years of head nurse experience and size of staff.

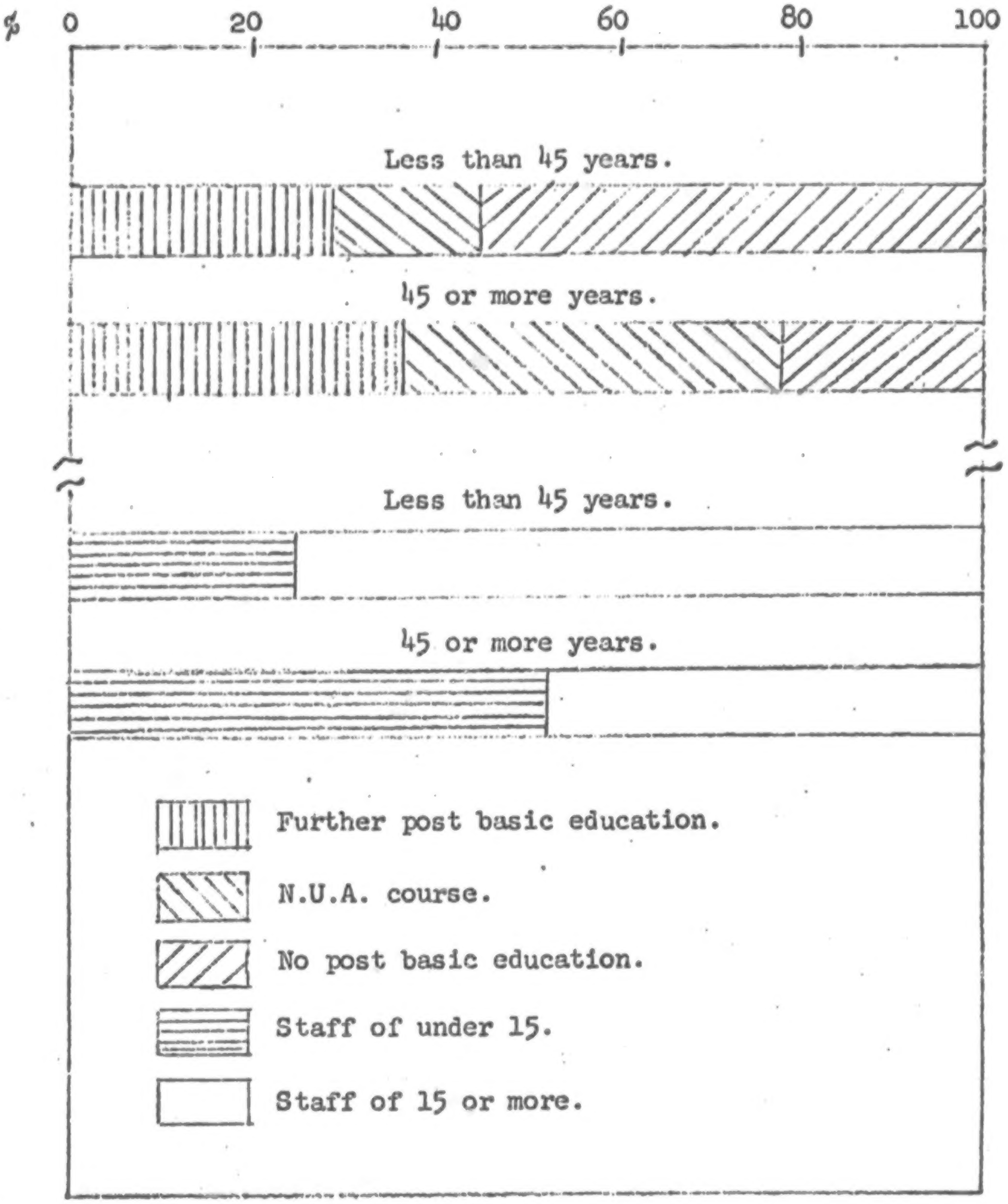

Fig. 17. Age related to significant background categories: post basic nursing education and size of staff.

differences in size of staff were commented on earlier with regard to those who were not married.

Of those with a score below the median of 11 on the Chapin scale, 32% graduated from nursing schools after 1950, 82% had more than 15 years of nursing experience; and 32% were responsible for nursing units of over 30 beds. Of those with a score over the median, 52% graduated from nursing schools after 1950, 52% had more than 15 years of nursing experience, and 61% were responsible for nursing units of over 30 beds. Although these scores appear to be confusing, the trend seems to be that the older more experienced nurses were among the lower scorers, and the younger less experienced nurses were among the higher scorers. This is not surprising when the societal trend is for younger adults, married or nonmarried, to be participants in community activities.

Of those who had high school graduation or less, 41% were not married. Of those with more than high school graduation, 77% were not married. (Figure 18) It was mentioned earlier that career goals would probably differ between those who were married and those who were not. Again, time of education was not elucidated at the time of the interviews. The relationship between years of education and marital status could not be determined from these data.

Of those with no post basic nursing education, 71% were under 45 years of age, and 59% were employed in smaller hospitals. Of those who had completed the N.U.A. course, 29% were under 45, and 43% were employed in smaller hospitals. Of those who had further nursing

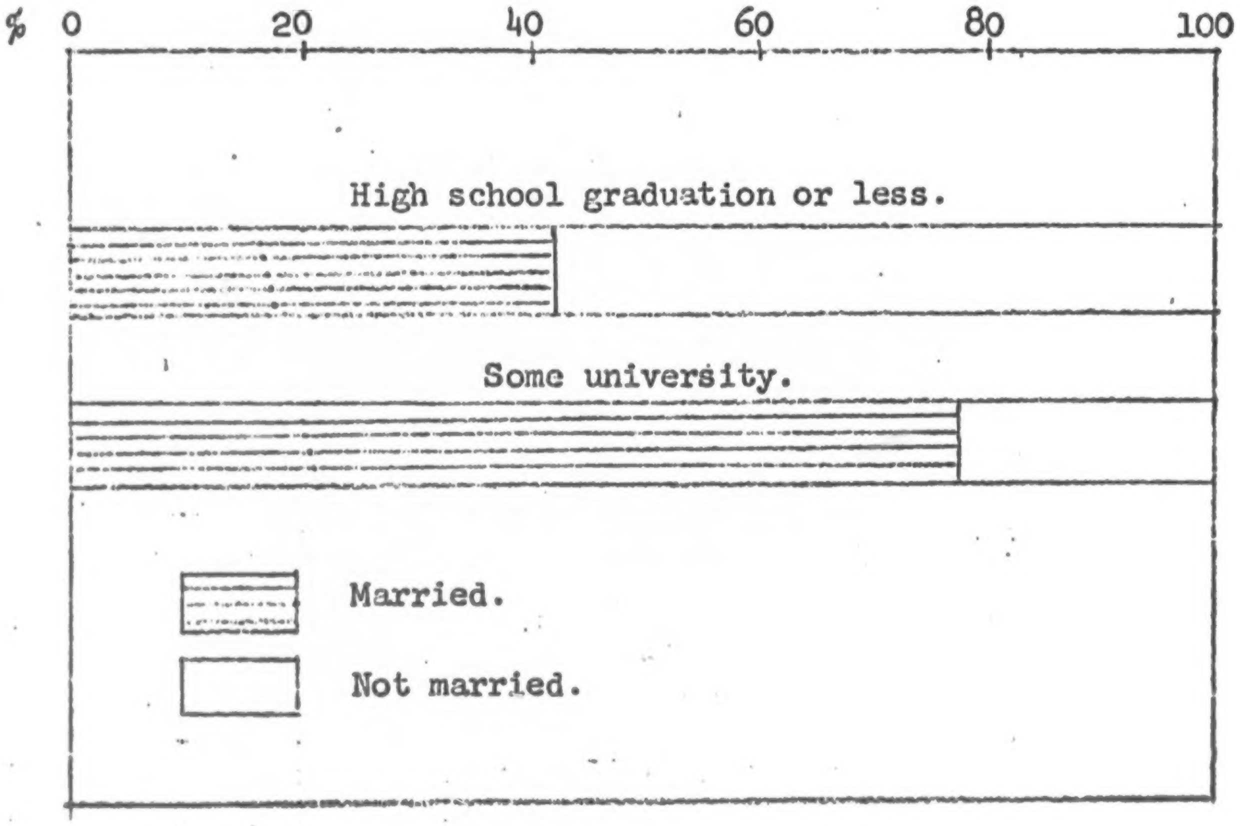

Fig. 18. Basic academic education related to significant background categories: marital status.

APPENDIX B

INSTITUTE INTERVIEW

1. Name ______________________ No. __________

2. Marital Status
   1. Single
   2. Married
   3. Widowed, divorced or separated

3. If married, husband's occupation ______________________

4. Number of children
   1. 0 - 5 years
   2. 6 - 10
   3. 11 - 15
   4. 15 or over

5. Age
   1. under 25 years
   2. 25 - 29
   3. 30 - 34
   4. 35 - 39
   5. 40 - 44
   6. 45 - 49
   7. 50 - 54
   8. 55 - 59
   9. 60 - 65

6. Gross annual salary
   1. under $3000
   2. 3000 - 3999
   3. 4000 - 4999
   4. 5000 - 5999
   5. 6000 - 6999
   6. 7000 - 7999
   7. 8000 - 8999
   8. 9000 or over

7. Names of organizations belonged to in past year, excluding church membership but including church organizations.

Total Score ______

Name of Organization	Attendance	Financial contribution	Member of Committee	Offices Held
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Total (X1)	(X2)	(X3)	(X4)	(X5)

Score

0
1 - 5
6 - 10
11 - 15
16 - 20
21 - 25
26 - 30
31 - 35
Over 35

8. What was the highest grade of school you completed?

1. Some high school
2. Junior matriculation or high school graduation
3. Senior matriculation or first year university
4. 2 years university
5. 3 years university
6. over 3 years university

9. Where did you take your basic nursing course?

1. B.C.
2. Canada (other than B.C.)
3. United States
4. Great Britain
5. Other, specify. ______________________

10. Year of graduation

1. 1920 - 1929
2. 1930 - 1939
3. 1940 - 1949
4. 1950 - 1959
5. 1960 - 1967

11. What type of hospital or institution was your course associated with? ______________________________

12. Post basic nursing education (give year).
    1. None
    2. CNA Correspondence course in ward administration
    3. University diploma course in
        a. public health nursing
        b. administration
        c. supervision
        d. teaching
        e. psychiatry
        f. other, specify _______________
    4. University degree(s)
        a. degree(s) ____________________
        b. specialty ____________________
    5. Other, specify ____________________

13. In the past five years, have you taken any nursing courses not covered in the previous question?
    1. None
    2. Course _____________ Institution ___________

14. What post high school training have you had other than nursing?
    1. None
    2. Business
    3. Secretarial
    4. University degree, specify field _____________
    5. Other, specify _________________________

15. In the past five years have you taken any non-nursing courses?
    1. Yes
    2. No

16. Are you interested in further courses in adult education?
    1. Yes
    2. No

17. How many years of experience have you had in nursing? _______

18. For how many years have you been a head nurse? ___________

19. What is the approximate bed count of your hospital? ________

20. What type of nursing unit are you working on? ____________

21. What is the bed count of the nursing unit? ________________

22. What number of personnel does your unit have? ___________

23. Kropp Verner attitude scale score.

24. What did you learn that was new at the Institute?

    How have you changed your evaluative procedure since the Institute?

APPENDIX C

STRUCTURED FORMAT FOR PERCEIVED CHANGE

I. No change

II. Change

  A. Knowledge

    1. Reawareness of previous knowledge.
    2. Better understanding of the reasons for evaluation.
    3. Better understanding of preparation of evaluations.
    4. Better understanding of recording or writing evaluations.
    5. Better understanding of disucssing evaluations.
    6. Others have similar problems.
    7. There are other points of view besides one's own.

  B. Attitude

    1. Different feeling about interviews.
    2. Different philosophy about evaluations.
    3. Evaluations are easier to do now.
    4. More confidence in doing evaluations.
    5. Expectations are now two way.
    6. There are other points of view besides one's own.
    7. More confidence in ability to fill position.

C. Practice

1. Supervision
   a) more observant of staff performance.
   b) more explanations and reasons to staff.
   c) more diplomatic and tactful.
   d) problems dealt with immediately.
2. Teaching
   a) teaching planned on observations of performance.
3. Orientation
   a) now doing orientations.
   b) planning new orientation.
   c) outlines expectations and/or job descriptions.
   d) more time spent with new staff members.
   e) orientation more specific and more detailed.
4. Anecdotal notes
   a) anecdotal notes now collected.
   b) more anecdotal notes kept.
   c) anecdotal notes more specific and objective.
   d) collects anecdotal notes written by other staff.
   e) collects and records comments on staff by doctors and patients.
5. Evaluation reports
   a) more objective.
   b) more future oriented.
   c) more careful in describing behavior.
   d) easier because more confident of facts.
   e) more head nurse discussions of evaluation.

6. Interviews

   a) more regular.

   b) more frequent.

   c) more informal.

   d) more two way discussions.

   e) more private and more planned.

   f) more praise and encouragement given.

   g) more specific.

   h) more objective.

   i) easier because reports are better.

   j) easier because facts are available.

APPENDIX D

THE KROPP VERNER ATTITUDE SCALE

From the statements below, which most closely describes your opinion of the Institute on Evaluation which you attended?

1. It was one of the most rewarding experiences I have ever had.
2. Exactly what I wanted.
3. I hope we can have another one in the near future.
4. It provided the kind of experience that I can apply to my own situation.
5. It helped me personally.
6. It solved some problems for me.
7. I think it served its purpose.
8. It had some merits.
9. It was fair.
10. It was neither very good nor very poor.
11. I was mildly disappointed.
12. It was not exactly what I needed.
13. It was too general.
14. I did not take any new ideas away.
15. It didn't hold my interest.
16. It was much too superficial.
17. I left dissatisfied.

18. It was very poorly planned.

19. I didn't learn a thing.

20. It was a complete waste of time.

APPENDIX E

THE LEARNING SITUATION

Learning is defined in the behavioral sciences as a change in behavior which is more or less permanent.[1] The definition is applicable to knowledge, attitude and skills, although only knowledge can be objectively measured. If new behavior is to be learned, the learner must have knowledge about this new behavior, attitudes which are positive toward this new behavior, and a situation where he can practice or use it. Acquisition of new behavior is, therefore, dependent upon learning, a need to change, a climate conducive for learning, and approval of the co-members of one's groups.

Knowledge

Knowledge is the acquisition of facts about one's world, and the frames of reference or cognitive configurations which the individual develops to keep his information classified, systematized, or logically sequenced.[2] Our cognitive world is constructed on what we think, believe, and expect. Hence, "the responses of the individual to persons and things are shaped by the way they look to him--his cognitive world."[3] As each person has a different experiential background, each has a different cognitive world. An egocentric assumption that 'our' cognitive world is the same as that of others leads to confusion and difficulties in interactions, communication and understanding.[4]

By the time a person is an adult, he has usually developed complex cognitive structures which he uses as anchors for any new material with which he is presented. These structures are concepts, which form as the person organizes, groups, and systematizes his knowledge. Harvey defines a concept as a mode of relatedness between the individual and his world.[5] When the person is presented with new material, he accepts and stores it in his memory. If the material has no relationship to anything he has stored before, he is likely to discard it, but if it is related to previous concepts, he adds it to his previous cognitive configurations by modifying these, or adding to them. On the whole, we do not like to change things too drastically as this would destroy our relationship with "our" world. We are more likely to distort the information we have received so that it will fit our preconceived concepts, even though these may have been formed with too little information. (This will be further discussed under Attitudes) Human beings dislike ambiguity or gaps in knowledge, and tend to bend or fill in what they already 'know' with fantasies and imagination. If nothing is presented to amend this, the person may have faulty concepts about many subjects. New information will change these concepts only in so far as the individual is willing to accept new ideas and change his cognitive patterns.

Usually concepts form from simple to complex, from concrete to abstract, and from discrete to systematic. Educational offerings should be based on a similar sequence.[6,7,8] The individual also strives for a logical consistency in this process of cognitive patterning. This does not always occur, however, because of changes which are constantly taking place in ourselves and in our world. The concepts one holds are reinforced and modified continually by the reactions of those around us as we seek their approval of our actions.[9] As a person develops maturity, there is a development of logical interrelatedness between his various concepts, giving his personality an integration of values and knowledge.[10] Concept formation and change occur readily for the integrated or 'open' person, since he can examine material readily. When a lack of interrelatedness leads to compartmentalization of concepts, rigidity and a 'closed' personality develop.[11] As concept formation and change are basic to problem solving, the open person is more likely to seek alternative pathways when an apparent solution is not tenable.[12]

Attitudes

Attitudes are the emotional components of the facts which a person stores, or the "feeling tone" about these ideas or concepts.[13] They become a part of cognitive configurations as these develop throughout childhood and adulthood.[14] Attitudes will have a decided influence on what a person can accept or use to alter cognitive patterns. Sherif states that an attitude is not a point on a continuum, but rather a range of latitude of acceptance.[15] Attitudes define what a person is and what he is not. Halloran describes attitudes as being our major equipment for dealing with reality, and, as such, they reflect our style of operation in coping with problems and in simplifying complex situations so we can deal with them.[16] Attitudes are learned along with knowledge and are built into cognitive concepts as these form. The greatest source of influence on attitude formation is the interpersonal relationships one has with important or significant others.[17] Thus, those in our groups at work or at home, will have a decided effect on how we feel about things and persons.[18]

Attitudes toward any new material add new dimensions to whether or not a person can 'learn' the material. If new material is within the 'latitude of acceptance', it will be handled as described on page 126, modifying or adding to existing cognitive configurations. However, if the material is outside his range of acceptance, the person will either reject it completely as meaningless to him, or he will change it in some way to make it acceptable. This is how people 'twist facts' or distort reasoning.[19]

Attitudes have degrees of emotional effect for the individual also, because they are part of a concept that is more or less meaningful to that individual. When a concept is very meaningful, it is well protected with defense mechanisms. Such a concept is considered a 'central concept', and has a low range of acceptance for change. The most central concept for most people is that of self. When new information pertains to a central concept, it will be accepted if it confirms his concepts, but rejected if it does not. A less meaningful concept has less emotional content, and is not so readily defended. Such a concept is considered a peripheral concept, and has a wide range of acceptance for change.[20] Thus, the person with most of his concepts in the peripheral sphere is more readily influenced than the person with a great number of central concepts.[21,22]

Practice

Skills are ways of behaving in coordinated, smooth, precise patterns as responses to the stimuli or cues of a situation.[23] Practice is usually defined as the repetition of learned sequences of behavior until the pattern is automatic or has become a habit.[24] Confusingly, in nursing, practice is used to denote the person 'practicing' nursing or working as a graduate nurse. Her skills are accepted as already acquired, although interpersonal relationship skills never become automatic. Thus in this paper the term practice has been used to denote the acquired skill rather than the acquisition of it.

In the acquisition of a new skill, the individual starts from a background of many already existing, highly developed general and specific skills. Each adult has hundreds of these skills, each skill with its own background of cognitive patterning.[25] As a person begins a new routine, he tries one of his existing habit patterns. From his internal feedback of 'feel' and the responses of his environment, he will adjust the pattern he tried, or try another. His original repertoire of responses and habits influence this markedly.[26]

Performance during the learning of a skill can be described as passing through the stages of cognition, fixation and automation.[27] The cognitive stage is the early stage, during which the person acquires the knowledge necessary for him to perform the behavior for which he is striving. This stage is one of confusion as the person makes many errors of wrong responses, or right responses at the wrong time. He has to learn the stimuli or cues in his environment which are relevant and irrelevant to his task.[28] Gradually he learns to match appropriate cues and responses as his information processing improves and his cognitive configurations develop. Fixation is the stage during which he refines his responses through further selection and discrimination. This is the longest period in learning a skill.[29] Gradually there are decreasing errors and increasingly smooth, precise and accurate responses. At this point automation or habit patterns have been established. (Fitts describes a cognitive set or habit as the preparation in advance for the probabilities or contingencies characterizing a certain situation.)[30] Skill learning therefore is a gradual shift in the factor structure of the skills as units become larger and cognitive sets or habits develop. The discontinuity of movement is lessened, and continuity becomes smooth.[31]

The Need to Change

Often a satisfactory and acceptable degree of competence in old patterns of behavior makes a person unwilling to relinquish the security his competence gives him for the untried and uncertain reactions the new behavior may produce. The new behavior seems less necessary or important to him than to someone who does not have satisfying patterns of behavior.

For learning to occur, the person must desire a change or something must be done to induce him to feel a need to change. For some, extrinsic rewards may be supplied through promotion, increased pay, encouragement, praise or other means which are meaningful to the learner. For others, the intrinsic gratification of learning alone is enough.

Role prescriptions provide some of the major motivations to change. Role is defined as "the pattern of wants and goals, beliefs, feelings, attitudes, values and actions which members of a community expect would characterize the typical occupant of a position. Roles prescribe the behavior expected of people in standard situations."[32] A position is defined as "a category or place in a system of social classification . . . recognized by a community. Each individual occupies multiple positions, associated with each of which is its role."[33] Merton states that the individual behaves in "regular role performance as a logical consequence of the system of sanctions imposed on those who fail to meet, and rewards those who do meet, the expectations of society."[34]

There are always incompatibilities within one role, and incompatibilities between roles.[35] The way an individual behaves in his roles reflects both his personality and the incompatible and conflicting demands and expectations of others. Role conflicts are solved through the person's decisions regarding the importance of others' expectations, and the punishments he may receive for noncompliance. When the role is not clearly defined, as often happens, the person has further conflicts with which to contend.

The conflicts and incompatibilities in a role cause much pressure on the incumbent of a position. When a person is new to the position, the various attributes of the role can be both confusing and conflicting. When solutions are not within sight, the incumbent may react with the behavior of her old position, becoming more and more dissatisfied as this behavior fails to resolve her conflicts.[36,37] Some of the problems are societal commonalities, such as those for anyone in a similar position; some are organizational with incongruent authority and responsibility in the position; and some are personal when the individual cannot resolve incongruent personal and role goals.

Within the nursing profession, there are often additional pressures arising from directing the work of others instead of doing actual patient care.[38,39] The nurse who has risen to a head nurse position has to conform to the norms of her new role and dissassociate herself from the group which she has left. For her new role she has to learn the values, attitudes and behaviors of the head nurse group, and how these differ from those she learned during her occupational socialization in becoming a staff nurse.[40] This change requires major changes in self concept for many nurses with considerable insecurity until the new role attributes are learned.[41,42,43,44] The ability to make adjustments and the experiential background of the individual determine the facility and ease with which she adjusts.[45,46,47]

Regardless of the extrinsic or intrinsic motivation, however, the person must desire the change. He has to perceive the change as useful to him, and adaptable to his past experience and his present social system.[48] By this it is meant, that he has to realize the use or meaningfulness of the new behavior to him through being able to relate it to what has happened to him in the past, and through his perception of the acceptability of the new behavior to those in his social groups. Whatever engenders a feeling of a need to change, the person tries to acquire the information he needs for the new behavior and to develop the attitudes he needs to adopt it. These are often influenced by the climate in which the new material is presented.

Climate for Learning

The learner needs a clear picture of the behavior or knowledge which he is to acquire, and an opportunity to practice any change for reinforcement of the new behavior. Information can be presented in many ways and under many different circumstances. Some of the ways which have been found conducive to learning were discovered through classroom experiments,[49] others were discovered through research into public opinion,[50,51] and much has been learned through trial and error.

Freedom from threat, permission to ventilate feelings, emotional support, and an opportunity to gain insight into one's feelings about the subject under consideration have been found to enable learning to occur. The degree of each of these required by any one individual will be dependent upon his knowledge and attitudes, and by the amount of change desired.[52]

Mild anxiety is necessary for learning to occur as complacency, apathy, and disinterest in change are characteristic of minimal anxiety.[53] Excess anxiety, however, leads to the activation of defense mechanisms and hence decreased communication and learning.[54]

Often the credibility of the communicator in the perception of the learner, the form and manner of the presentation, and the circumstances of the delivery have pronounced effects on the learner.[55,56,57]

The Effect of Small Groups

> Man is a social being and . . . is dependent upon others to a considerable degree. He has lived, played, worshipped, worked, and has been educated in groups throughout his

> existence. The worst punishment which society can inflict upon him is the living death of isolation . . . . The continuity of mankind has been primarily through small groups: it cannot endure without them.[58]

A person's membership in any group depends upon how well his aspirations and objectives are congruent with those he perceives as the norms of his group.[59] The more he participates in forming group consensus, the more involved his membership becomes. With greater involvement, there is more conformity, liking, security. When group approval is not apparent, the member may experience frustration and conflict.[60] A work situation is particularly vulnerable in this respect as changes in personnel bring changes in group membership and group norms. A new group member will often conform to patterns which previous group members have found comfortable and satisfying, in order to gain acceptance. On the opposite extreme, a lack of defined expectations may result in frustration and conflict for all group members.[61,62]

The successful worker, who was well accepted within his work group may feel cut off from his former associates when he is promoted to a supervisory position. He is now expected to conform to the behavior of his new group and former co-workers expect leadership from him. Adjustment to a new role is easier with a well organized plan of orientation, and encouragement and support as needed.[63]

It is the responsibility of the supervisory person to plan for changes in the work group. Unless he gains his subordinates' cooperation, little will happen. Cooperation is facilitated by mutual planning of objectives and discussions of accomplishments. The motivation to change is often the result of the group process and is most effective when it is engendered and reinforced within the group.[64,65,66,67,68]

Conferences, workshops, institutes or other meetings of those in similar positions in different agencies, stimulate and encourage the potentials for "learning, reorientation, and creative thinking" already present in those who attend.[69] Group process is definitely a factor at such gatherings, and can be used constructively to influence change.

The social system of each small group possesses a structure of interaction or a relational system, a system of customary behavior and a system of values.[70] These systems are interdependent and thus enhance and support each other. A social system exists in a certain environment, and changes in either are reciprocal. The relational system is one of interpersonal relationships built upon responsiveness, understanding and sensitivity to others. The customary behavior and the value system govern how group members should behave and feel.

> Personal life satisfaction . . . depends upon our communion with people . . . . Society can only be understood through communication; it can only stay together as a society by proper communication . . . . Dialogue . . .begins in an act of faith: the assumption that those who converse speak in honesty for the purpose of reaching understanding, and with generosity toward each other . . . . Dialogue demands that we earn the right to be heard by lending our ears to what others have to say. The only way we can get another person's idea of ourselves and our projects is by listening to him talk.[71]

Communication is the process of a sender encoding and transmitting a message which is received and decoded by a receiver.[72] When there is no blockage, the recipient understands the message which the sender meant him to receive. The composite parts of the process include a similar language symbolism, the emotional component of the message to either the sender or the receiver, the nonverbal aspects of the communication sent, the attitudes engendered in the receiver, and the relevance of the material to the receiver.[73,74,75]

Communication and interaction are inseparable. Much interaction is spontaneously evolved and each encounter leads to feelings on a continuum between acceptance and rejection. The prime motivation in any interaction is the validation and protection of the self. Past experience will determine the quality of an individual's response and the extent to which he perceives other persons, events, and situations as threats.[76] This perception influences the activation of his defense mechanisms and hence his ability to communicate. In threatening situations, which can occur for anyone, the person may not perceive the information which is available, he may misinterpret it to bring it into line with existing concepts, or he may receive the information adequately but be unable to respond through ignorance or fear.[77]

Communication is increased when the subject is important to the group, when the group is cohesive, when friendships exist in the group, and when the group is small. With increasing membership in a group, there is increasing heterogeneity of ideas and decreasing individual participation and involvement.[78] In very large groups, the 'anonymity phenomenon',[79] or alienation from group membership may occur.[80] Either of these may lead to a lack of expectations of performance, and a lack of responsibility and participation in group endeavour.

Presentation of New Material

When the objectives of a presentation or lecture appear to be congruent with the worker's personal objectives, he is more receptive to the new information. As meaningfulness is evident, he can relate it to earlier experience through the reorganization of his existing concepts.

> The retrainee is quite a different individual than the young trainee. Our experience with this group shows them to be . . . far more highly motivated, realistic, insightful, responsible, and generally more stable. Their goals are generally fixed, long-range in nature, job oriented, and they are far more strongly committed to these goals than are the younger students.[81]

Many of the courses or lectures which people attend do not present 'new' material but rather information which the person had earlier received and stored. The 'refresher' course tends to bring into consciousness this 'forgotten' material.[82] If the material is presented in a different context or from a different point of view it becomes related more meaningfully to existing concepts. In this way the person will be more likely to use it.[83,84] Personal growth is dependent upon the incorporation of the new with the old, or in bringing into meaningful focus previously learned information.

At an institute where small group discussions are employed, an individual tends to become involved in the group process. In so doing, he expresses his ideas and thoughts to group members, and receives feedback from them. The approval or disapproval inherent in group participation may alter his feeling of a need to change. Within the small group the person often discovers that his major problems are those common to his position. These problems may be the societal commonalities mentioned earlier, or they may be of organizational origin, only extant in his employing agency, or only in a specific type of agency.

The group may give the person feelings of adequacy and competency which were lacking earlier as he was not aware that others shared the same problems. He may also find that his own personal solutions are deemed adequate by his peers. The group may, on the other hand, make him realize that there are better ways of solving problems than those he had been using and motivate him to try new behaviors. The interactions and communication patterns within a small group can have a major influence on the group members. Especially when change is to be effected and new material is to be learned, consideration of the group process is important.

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